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New Orleans Medical
and
Surgical Journal

Vol. 93 AUGUST, 1940 No. 2

RUDOLPH MATAS
DEAN OF AMERICAN SURGERY*

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"Bold when sure; cautious in danger; kind to the sick; considerate of your fellow-workers; uninfluenced by gain . . ."
Guy de Chauliac.

We are gathered together this happy evening to do honor to a great institution, an institution as much a part of the life of Louisiana and of this romantic and colorful City of New Orleans as the great river which flows by your doors. This institution moreover has spread beyond civic and provincial limits until it may now be fairly said that its works and discoveries permeate the civilized world. It is an institution with an amiable government, a universal membership and a simple creed,—let us work for the good of others. It transcends all partisanship and it offers hope to suffering humanity. Beginning simply in the mind of an individual it now enrolls thousands upon thousands of devotees. It is already indestructible and has taken its place with eternity. We who come together tonight are happy to be its servants and I who speak for you do so with the greatest humility knowing full well that no equal honor will ever reach the shoulders of any of us.

The institution of which I speak is, of course, Rudolph Matas. Rudolph Matas, for many years dean of American surgery, is no longer an individual. He is a corner-stone of American surgery, securely builded into its very foundations as something upon which our professional offspring may lean with confidence and benefit throughout the years to come. By the vigor and brilliance of his intellect and the cordiality of his spirit he has set himself securely in the high seats of our surgical profession amongst such giants as Walter Reed, Ephraim McDowell, Valentine Mott, William Halsted and Harvey Cushing. And though he has labored long beyond the three score years and ten set in the "Good Book" as a proper limit for humanity, he still shows us the face and spirit of youth. At Brussels, Belgium, some two years ago I spoke of him as having in addition the "soul of an angel" which characteristically pictures his warm and generous spirit. How can we honor one already so laden with decorations and victories? Blessed by a personal friendship which I value far more than the honors that come with growing up, I feel certain that this man's spirit will be greatly moved by your demonstration of tonight. For one of his greatest characteristics is his simplicity!

My personal debt is a deep one not to be wiped out by this trip from snow-clad New England to your happy city nor by any series of trips to the shrine of this institution. As a young surgeon in 1924 I described before the American Surgical Association some experiences I had acquired in attempting to enlarge the stenosed mitral valve in

*Presented at the fourth annual meeting of the New Orleans Graduate Medical Assembly, February 26, 1940.

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chronic heart disease. I finished,—my mouth parched, my hands and knees trembling,—only to be revivified and stimulated by kind and thoughtful words emanating from the Rudolph Matas institution. It was just the fillip the young surgeon needed and came in that friendly and cordial spirit so seldom experienced in New England.

How can we evaluate such an institution as Rudolph Matas? There is the great surgeon whose skill, daring and good sense have brought relief to suffering individuals; there is the stimulating, affectionate and eminent teacher whose pupils have spread his gospel far and wide; there is the tireless worker for civic and professional betterment, always espousing the just and worthwhile cause seeking to bring together all partisan elements for the common weal; and finally there is the adult institution spreading its benificent influence not only throughout our whole country but throughout the civilized world!

It has been said that the proper study of mankind is man and perhaps by a brief study of our beloved and honored guest we shall see how it is such institutions arise and thus place honor where honor is due. We see the beginnings of our institution in Gerona, Spain, where his parents' families had for years been sturdy, successful, farmers, merchants, priests and municipal office holders. That his father and mother were both one of nine children emphasizes the vigor of his inheritance and the robust health of our institution tonight reflects better than words its debt to these progenitors. Immediately after marriage these parents moved to New Orleans (1856), where the bride's brother-in-law assisted the father of our institution in establishing a pharmacy. Immediately the young bridegroom commenced the study of English and medicine and by 1859 graduated from the New Orleans School of Medicine. Here again the abilities of the son are mirrored in the parents. Almost coincidental with receiving this degree in medicine, fire destroyed the pharmacy and the family moved to Bonnet Carré where our institution was born September 12, 1860. The Civil War soon interrupted a medical career for the father of our institution, and after a successful venture in the cattle business the family moved to Paris, France, that the father might receive further training in ophthalmology. Thus will a Spanish inheritance and only a four year glimpse of America our prodigy moved to Paris for his early education. Only two years later the family moved again and settled in Barcelona. But by 1867 they returned to New Orleans and shortly thereafter moved to the Mexican Border. Up to now the polyglot and peripatetic education of our institution lacked English which was soon to be learned in the public schools of Brownsville, Texas. This was followed by two years in a New Orleans college and then further studies at the College of St. John in Matamoros. At the same time he worked in a pharmacy and finally matriculated at the Medical School of the University of Louisiana, now Tulane. Here he progressed rapidly and in 1877 won in competitive examination the post of resident intern at Charity Hospital. Upon graduation in 1880 he became Chief of Clinic and in 1894 Professor of Surgery, maintaining active association at this Hospital until 1927 when he retired from his teaching position. Thus for 50 years he was actively associated with your great and world-renowned Charity Hospital.

This glimpse into the background of our institution shows that its characteristic earmarks of industry, scholarship and wholehearted devotion to the task at hand were also to be seen in its antecedents and that the robustness and vigor which has so long characterized it was a family trait.

There is not the time to review Dr. Matas' postgraduate education. It was, as was his whole education, a continuous and growing experience. He traveled to all the great centers in our own country and in 1886 was in both Paris and Barcelona where, imbued with his responsibilities as demonstrator of anatomy, he sought out chiefly the anatomic departments. This was characteristic of the man. What he had to do he wished to do very well. With his traveling he made friends everywhere and his inquisitive and

scholarly nature increased his education day by day so that no one viewing his career in retrospect could but marvel at his steadily increasing success.

Moreover we must envisage the surgery of that day. Bacteriology was established and surgery was progressing from the antiseptic to the aseptic method. Dr. Matas early realized the simpler and more positive value of sterilization by heat. Next he turned his interest to local and spinal anesthesia and was one of the very first to ultilize the latter method. Indeed his description of his first attempt at spinal anesthesia with cocaine and particularly his observations of the after effects was one of the most valuable contributions in this field at that time. This was shortly followed (1888) by his papers dealing with the replacement of fluid for shock, hemorrhage, and other surgical complication, by the "continued intravenous drip" route, a method now popularized and in every day use in all our hospitals. And by 1911 he was advocating gastro-duodenal tube syphonage for intestinal obstruction, peritonitis and paralytic ileus. His modesty has allowed others to have their names attached to such life-saving methods, though priority of thought and effort belong to him. It is just this spirit which has raised him high above his fellow workers. Later his interests roamed everywhere. His studies in the field of intrathoracic surgery led him to assist in the development of apparatus for keeping the lung expanded when the chest was open.

And finally his work on aneurysm! It is known to the world and accepted by all as the greatest contribution in the field of vascular surgery. In such an intimate gathering it should be of interest to inquire why and how this interest in aneurysm arose. Let us go back to the epoch preceding the advent of our institution. First there were not a great many surgical operations except those of necessity, secondly most surgeons entered this field through anatomy and thirdly the ligation of the great vessels for aneurysm was looked upon in those days as the surgeons' greatest claim for recognition. How could the young ambitious, anatomically minded young Matas do otherwise than yield to this incentive, especially when we know his predecessor Smyth had won unique success by ligation of the innominate artery. Moreover, this natural ambition was presented with unsurpassed material in the wards of the Charity Hospital.

A study of his own notes of his first case, a 28 year old negro submitted to operation March 30, 1880, reveals the reason for developing his method of endo- or intrasacular aneurysmorrhaphy. Here we see the reasons for his success, his many contributions and the foundation of the Rudolph Matas institution. Now with our eyes opened by his works it seems simple. The facts had been the same from time immemorial but observation had been faulty. Matas noted that the reason for failure by ligation above or below the sac, or both, lay in the collateral circulation. Extirpation in this case was fraught with danger because of the important nerves practically incorporated in the walls of the sac. Immediately he performed what was safest for the patient and also obliterated the cause of the recurrence,—that was obliteration of the collateral circulation from within the sac. All over the civilized world this procedure, now perfected and explained by our institution, has brought comfort and happiness to many. In the development of this procedure we see, as Guy de Chauliac stated in his characteristics for the surgeon, the rare combination of boldness and caution.

And now let us turn for a moment from the scientific contributions to those of a more general nature, for this institution embraces all phases of life. Our institution has been a backbone in your State in medical education; in the harmonious workings of your medical colleagues; its chief, when President of the Louisiana State Medical Society, was largely responsible for the beneficent Medical Practice Act which regulates your professional work; its fountain head has taken part in every effort here in the last half century to improve your sanitation and your public health. In this relation it is difficult to add to the encomiums heaped upon Dr. Matas so recently as a

month ago when the sectional meeting of the American College of Surgeons was held here. His own oration relating to "What Medicine Has Done for the Welfare of the People of New Orleans and Louisiana" is in part autobiographic for in every advance he was a pioneer and a crusader daring the criticism of those less far seeing and less courageous. His recital of the advantages to your community of the benefits which have come through a knowledge of the causes, prevention or control of yellow fever, malaria, typhoid, typhus, cholera, bubonic plague, smallpox, diphtheria, and scarlet fever, are but a recital of the age old conflict between science and public opinion. It is common knowledge that many of the great figures of science were either scorned by the people or actually tortured because they dared to espouse openly discoveries which seemed unorthodox, though soon to benefit mankind. We have only to recall that Michael Servetus, who discovered the pulmonary circulation, was burned at the stake with all his books because he dared to tell the truth. We remember that in 1165 the Edict of Tours (Ecclesia Abhorret a Sanguine) declared surgery was not respectable. And we know that Dr. Zabdiel Boylston Adams, of Boston, in our early colonial day was chased by a mob and his life threatened because he had dared to inoculate a man with smallpox in order to protect him from a greater disaster. Dr. Matas' influence in this community has been as daring as those of the great figures in America who have long since departed. Beginning with his service in 1879 as clerk and laboratory assistant to the Havana Yellow Fever Commission of the U. S. National Board of Health, he has often, in the face of opposition, steadily labored for this great community. For this civic stand alone he deserves your perpetual gratitude. At the time of the Centennial of Medical Education in New Orleans in 1935 he spoke of "the influence of the last 100 years of medical education on the culture, growth and prosperity of New Orleans", but in this delightful and careful appraisal you will find no mention of his personal role. We who know him can appreciate this, for no man ever was more unassuming and self effacing or more apt to give praise and honor to others.

Dr. Matas, we rejoice to salute you as a man, as a surgeon, as an American institution. We have no desire to embarrass you, still young in spirit, with an epitaph and we realize that eulogy is hard to bear, but it is indeed a commonplace of our profession that your accomplishments exceed those of the teachers you yourself have so often extolled. If Chaillé, Richardson, Hunt, Bemiss, and Miles were here they would join us in this acclaim and they would agree that the prophetic words spoken by Andrew Woods Smyth have long been fulfilled and surpassed. You will remember that during the excitement which arose on the occasion of selecting Dr. Miles' successor, lay, civic and professional groups arose as a unit to urge your candidacy for the post which you adorned so gloriously for thirty-three years. Perhaps you recall Dr. Smyth's words: "Dr. Matas has genuine ability, which, in my judgment is superior in many respects to genius itself. He is beyond question the greatest surgeon New Orleans has ever possessed. There is nothing that he teaches that he does not exhaust. . . . I feel certain that the future will certainly corroborate the opinion which I now express regarding Dr. Matas, and any honor bestowed upon him will be justfied by history."

We, your friends, knowing of your eminent qualities of heart and mind, rejoice in all that has come to you. It is not my purpose to cite the honors and decorations which might have tainted the spirit of one lacking the beautiful humility and simplicity of your character. The impress of your personality upon students, associates, patients and colleagues is far above your scientific benefactions and is the corner-stone of the institution we celebrate tonight. We know that the love so richly expressed by these your friends will endure in your mind and heart long after the degrees, medals and citations which have been heaped upon you in past years have crumbled into dust. For you are a master in whose footsteps all are proud to follow.

Rudolph Matas, it is the ardent prayer of each one of us here tonight that in the years to come,—just as the Father of the Waters, which has made Louisiana to flower through the centuries, will continue to enrich this land,—you and your good deeds will serve and benefit mankind. For of you, as justly as of any other man, it may be said in the words of Abraham Lincoln, that you taught "hope to all, despair to none."

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THE MEDICAL SOCIETIES OF LOUISIANA PRIOR TO THE WAR BETWEEN THE STATES

WILLIAM DOSITÉ POSTELL,
M. S., B. S. IN L. S.*
NEW ORLEANS

PART I

THE BACKGROUND OF MEDICAL PRACTICE

Historians of the future, like readers of the present, will owe a great debt to Dr. A. E. Fossier for his "record of things past."[1] In his history of Charity Hospital from its founding in 1736 as L'hôpital des Pauvres de la Charité to the date of writing (1923) and in his similar history of the Orleans Parish Medical Society from its organization in 1878 to the date of writing (1928), he has incorporated a vast amount of material dealing with the practice of medicine in New Orleans and Louisiana during those years. On the other hand, nothing seems to have been written concerning the medical societies of the State of Louisiana prior to the War between the States, and it is the aim of this paper to collect and record such material as can be gathered concerning them.

THE FRENCH AND SPANISH PERIODS

Up to the time of the Louisiana Purchase in 1803, very little seems to have been done either privately or publicly for the protection of the health of the inhabitants of the Mississippi Valley. Even after the founding of New Orleans and the institution of a city government in 1718, the entire territory was apparently without any form of quarantine restrictions or other organized health activity. Physicians and surgeons, most of whom were graduates of the University of Paris, were sent from the mother country to minister to the needs of the colony, but there is no record of the organization of a board of health or of any similar action by them or by the government. There was not very much more activity, furthermore, during the period of the Spanish domination.

The founding of Charity Hospital is one of the few bright spots in the medical history of these years. In 1736 a French sailor, Jean Louis, who had become a resident of New Orleans and who had earned what he possessed "in this country irreproachably," left the residue of his estate to found a hospital for the poor of New Orleans. It bore the name of St. John, and the following year Bienville wrote to the Minister in France that it served the dual purpose of hospital and asylum to the indigent poor and that it had five patients. In 1779 the building was destroyed by a hurricane which left only the kitchen and storehouse, and for the next years the sick paupers wandered through the city and perished on the streets. No record exists of the physicians who practiced in the first hospital and during this time and for several years thereafter professional men seem to have had little to do with the management of the institution.

In 1782 funds for rebuilding, which had been offered as soon as the hospital was destroyed, were finally accepted by King Charles III of Spain from Don Andreas de Almonaster y Roxas, a wealthy nobleman. The gift was in the sum of $114,000, and the new institution, which was completed in 1784, was named Hôpital St. Charles. It received thereafter frequent legacies in the wills of pious French citizens, but conditions in it were chaotic, chiefly because appointments were made entirely on a patronage basis.

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In 1770 the Governor of Louisiana, Alexandro O'Reilly,* issued what is apparently the first decree[2] relative to the practice of medicine and surgery in the Colony. It read: "No surgeon shall have the right to practice surgery and medicine unless he produce his documents, his certificates of study, his books, his instruments; unless he submit to an examination before the King's physician; unless he have certificates of good character and of Catholic faith."

Rules and regulations for the duties of physicians and surgeons were also laid down in some detail and with considerable commonsense. Governor O'Reilly was extremely unpopular, but this document is additional testimony to his remarkable executive ability and good judgment.

It was during the period of Spanish domination that yellow fever first made its appearance in New Orleans. A disease which closely resembled it had ravaged the city in 1765, but the date of the first epidemic is usually given as 1791 or 1796. It was highly fatal from the first, and the death rate was at times as high as 72.86 per thousand. On May 9, 1794, Baron de Carondelet, who was then the governor, recommended the excavation of what today is known as the Old Basin Canal, for the purpose of draining the stagnant water of the city into Bayou St. John. This stagnant water was regarded, probably with considerable reason, as the cause of the epidemics which were proving so fatal in the city.

THE AMERICAN PERIOD

Immediately after the American occupation of the Colony, in 1803, more active attempts were made to improve sanitary conditions in New Orleans. In 1806 the City Council recommended by resolution that the forts around the city be evacuated and destroyed and that the ditches which surrounded them be filled up. Governor Claiborne,[3] in reply to the resolution, wrote: "I am strongly impressed with the opinion that the stagnant water which accumulates in the old fortifications must prove injurious to the health of the city, that I cheerfully consent to the leveling of all of them, except those of Forts St. Charles and St. Louis . . ."

Two years later the Council[4] requested that the Governor consent to the leveling of Fort St. Louis and the filling up of the trenches which surrounded it ". . . inasmuch as it impeded the communication between the town and the suburb St. Mary, and the trenches were receptacles of stagnant water . . ."

In the same year (1808) the Governor himself recommended to the Legislature the policy of making general laws to enforce cleanliness and to subject the shipping entering the Mississippi River to quarantine regulations. It was not until ten years later, however, that the first Board of Health was appointed and quarantine regulations were drawn up. Governor Villeré urged both steps in his annual message to the Legislature (January 6, 1818)[5] and the necessary acts were passed and were approved by him March 17, 1818.[6]

Meantime steps had been taken to improve the deplorable conditions at Charity Hospital. The first legislative act referring to it was passed by the Legislative Assembly of the Territory of Orleans in 1808 and was approved by the Governor March 8 of that year. Three years later the Marquise de Pontalba relinquished to the city her rights and privileges as patroness of the Hospital and made it possible for the Legislature to enact the law which may be considered the charter of the present institution. This act, among other items, provided for a Council of Administrators, six of whom were to be appointed by the Governor and three by the City Council.

In 1809 the hospital was destroyed by a fire which swept the city and for the next years the patients were moved from one temporary building to another with so much suffering that, according to the rec-

*Names frequently vary in spelling in different documents and even in the same document, and initials are frequently omitted. The author in all instances has followed the spelling of the document used for the immediate reference.

ord, "no one, however wretched and poor, will now consent to be committed to that Hospital." In 1814 ground was purchased and a 120-bed building erected which served also as an asylum for lost children. A house surgeon was put in charge, and the physicians of the city visited the institution in turn. In 1832 the site on which the hospital is now located was purchased and a building was erected the next year at a cost of $150,000. This building was still in use in 1936, when the grounds were cleared for the erection of the present new and modern building.

REGULATIONS CONCERNING THE PRACTICE OF MEDICINE

In 1808 the Legislature passed the first act establishing the standards and procedure for those who wished to practice medicine in New Orleans. It was called "An Act concerning Physicians, Surgeons and Apothecaries," and it was signed by Governor W. C. C. Claiborne, March 23 of that year.[7] It provided for an Examining Board composed of four physicians and surgeons to be appointed by the Mayor of New Orleans from among the oldest practitioners in the city. The candidate who desired the right to practice in the city must present to the Board the diploma from the university, school or college in which he had pursued his medical studies, and must, in addition, submit to examination by the Board.

Most of the physicians who had drifted into New Orleans after the Louisiana Purchase were graduates of the Eastern medical schools, including the University of Pennsylvania, Jefferson Medical College, the University of the City of New York, and Harvard Medical College. The French physicians, as has been pointed out, were chiefly educated in Paris. Along with these legitimate physicians were a large number of quacks, and the act of 1808, laudable as was its purpose, had the defect of making no provision for their elimination, for physicians residing in the Territory prior to its passage were not required to submit to examination. The act also failed to provide any penalty for failure to comply with the licensing provision, which again left the field open for quacks and incompetents.

This deplorable state of affairs continued until 1816, when a new act was passed prescribing the formalities to be observed for the practice of physic or the profession of apothecary within the State of Louisiana.[8] Penalties were now enacted for failure to comply with its provisions. The examining board set up by this act consisted of four physicians and one apothecary, all to be appointed by the Governor instead of by the Mayor, as in the former act. In 1817 a supplementary act was passed setting up two medical examining boards for the two judicial districts of the state. The Eastern Board was to meet in New Orleans and the Western Board in Opelousas.

SANITARY REGULATIONS

Public health regulations, restrictions upon the unlicensed practice of medicine and surgery, and improvement of conditions at Charity Hospital had resulted, however, in little improvement in the general health. Yellow fever continued its devastation, and in 1818, 1,152 persons died of it. The people themselves, furthermore, either had no faith in quarantine laws, or, what seems more likely, objected to the fashion in which these laws interfered with the commerce of the city. Whatever the reason, the 1818 act[9] which had established the Board of Health and set up quarantine laws was repealed in less than a year (March 6, 1819) and the Governor was authorized to establish quarantine regulations at his discretion and by proclamation.

December 18, 1820, Governor Robertson, in his inaugural message, urged the Legislature to establish quarantine regulations against yellow fever, and in February, 1821, the Legislature passed the requested act. It created a Board of Health "with plenary powers, legislative, judicial, executive, pecuniary and sanitary modeled after codes the most rigid and enforced by the heaviest penalties." The regulations were put into effect in March of that year and continued in effect until February 19, 1825 when, apparently because of lack of faith in their efficacy, they were again repealed.[10]

An ordinance for the establishment of another Board of Health in New Orleans was again passed by the General Council in June, 1841, and the Board functioned during that year. During this period, however, another epidemic of yellow fever occurred, destroying 1,641 of the inhabitants of the city, the interest of the members fell off, and the Board dissolved itself in 1843. Several apparently abortive attempts to re-establish it are observed in the Acts of the General Council dated August 15, 1846, and June 23, 1847, and in the Acts of the Legislature of Louisiana dated March 6 and May 15, 1848.[11]

On March 15, 1855, an effective act was finally passed. In his Report of the Board of Health for 1882 Dr. Joseph E. Jones[12] wrote: "All the great sanitary and quarantine measures of the past 27 years in Louisiana, may be directly or indirectly traced to the act 'to establish quarantine for the protection of the State' approved by P. O. Hébert, Governor of the State of Louisiana, on the fifteenth of March, 1855. During the preceding 155 years of the existence of the Colony, province and State of Louisiana, the sanitary and quarantine efforts of the people were spasmodic, unsatisfactory and of short duration; and as a consequence, at frequent and short intervals, the people were decimated by foreign pestilence, imported by maritime men and immigrants . . . up to the present moment the great principles embodied in the twenty-nine sections of this act have not been withdrawn."

In the decade beginning in 1830 New Orleans in some respects reached the greatest development in its history. Its harbors were crowded with shipping from all over the world, and its people as a whole were prosperous. Yet with all the prosperity, as can be gathered from the foregoing statement of facts, conditions were incredibly bad as to health and sanitation, and the death rate was nothing short of appalling.

MEDICAL EDUCATION

It was at this time that the first medical school in Louisiana was organized by the efforts of a few physicians, Drs. Thomas Hunt, John Harrison, Charles A. Luzenberg, J. Monroe Mackie, Thomas R. Inglass, Augustus Cenas, and Edward H. Barton. The French-speaking physicians of the city, who had chiefly been educated in Paris, were very much opposed to the idea, but the school nevertheless opened January 5, 1835, with eleven students and with a few friends of the Faculty as guests at the lectures. This school, which is now Tulane University of Louisiana, has had a continuous existence since that time with the exception of a few years during the War between the States when all educational efforts were in abeyance.

It is interesting to note the reasons why the founders[13] selected New Orleans as the site of the school, for the words have a very modern ring: "Because its hospitals, which will be opened to the undersigned for the purpose of instruction, are the largest in the Southern and Western states, so that practical medicine and surgery can be taught at the bedside of the patient, the only place for this study."

In 1843 the professors of this College of Louisiana petitioned the Legislature and obtained the right to attend the wards of the hospital free of charge for ten years, a privilege which the other physicians of the city did not look upon with equanimity. At the same time six students "of good moral character" were permitted to live in the hospital and do minor operations.

November 7, 1856, another medical school, the New Orleans School of Medicine, opened its doors for the first time. At this time Charity Hospital had no out-patient department and the dispensary which the new school operated was the only out-patient department in the whole Southwest and was hailed as a distinct contribution toward medical education. The first faculty consisted of Drs. E. D. Fenner (Dean), A. Forster Axson, Thomas Peniston, Samuel Chopin, Isaac L. Crawcour, Howard Smith, John M. W. Picton, D. Warren Brickell, Cornelius C. Beard, and Anthony A. Peniston. The school continued with varying success for a number of years, but was finally forced to close its doors in 1870.

Meantime the Special School of Medicine of the Louisiana Seminary of Learning lasted only for a single session, in 1865.

In 1837 a site upon which to erect a marine hospital for the port of New Orleans was purchased at Macdonough's on the right bank of the Mississippi River, opposite New Orleans. Building was begun in 1838 and was completed in 1849, at a total expenditure of $122,772.70.

This, in brief, was the situation in Louisiana in respect to the practice of medicine, medical education, hospitals, and board of health and sanitary regulations from the founding of the Colony, through successive French, Spanish and American rule, up to the War between the States.

PART II

THE MEDICAL SOCIETIES OF NEW ORLEANS 1817-1854

THE FIRST SOCIÉTÉ MÉDICALE DE LA NOUVELLE ORLÉANS

The yellow fever epidemic of 1817 seems first to have made it clear to the physicians of New Orleans that some organized effort on their part was necessary to promote the health of the city and to combat the ravages of this particular disease. Accordingly, the Société Médicale de la Nouvelle Orléans was organized in that year and continued active until 1821. It was reorganized in 1835 and lapsed again in 1837, continuing inactive until 1859, when it was organized for the third time, to end its activities finally in 1861.

A brief notice, printed in French and English, in the Courrier de la Louisiane[14] for January 7, 1818, advises that: "The Medical Society of New Orleans will hold its first public sitting on Sunday next the 11th at 12 o'clock in the city council room.

Jan. 5 Taillefer, Secretary"

The society was legally incorporated in 1818 by an Act[15] which states in part:

"Sec. 1. Be it enacted by the Senate and House of Representatives of the State of Louisiana in general assembly concerned: That the members of said Medical Society, that is to say V. J. B. Trabue, Cyprion Gros, and all such persons who may be associated with them for the purpose aforesaid, they and the same persons are, and shall be a body corporate and politic, for and during the space of fifteen years, in deed and in law, by the name and style of 'The Medical Society of New Orleans' . . . to have succession for and during the term of fifteen years . . .

"Sec. 5. And be it further enacted, that the purpose of the aforesaid incorporation, being exclusively for the development of medical knowledge and the extension of science in general . . .

Signed

Myre. Guichard
Speaker of House of Representatives
N. Meriarn
President of the Senate.

Approved Feb. 16, 1818"

Also of interest is an Act of the Legislature[16] approved February 28, 1818, authorizing the Medical Society " . . . to raise by lottery a sum of money not exceeding fifteen thousand dollars for the purpose of purchasing a library, philosophical apparatus . . . and defraying other incidental expenses of the institutions."

Whether the Society ever took advantage of this permission is not clear, but there was nothing unusual in it. At this time it was entirely proper to raise money for churches, schools and other worthy institutions by lottery, and Charity Hospital regularly received part of its funds from this source. No remains of the proposed library or philosophical apparatus, however, exist today.

One of the first acts of the Society after its first organization seems to have been an analysis of the causes of the yellow fever epidemic of 1817 and the treatment of patients during it. The report, which was prepared by Drs. Gross and Geradin and which was entitled "Rapport fait à la Société Médicale, sur la fiévre jaune qui a regné pendant l'été de 1817," was apparently well drawn, for it was quoted in part in the American Medical Recorder of 1819.[17]

It was also referred to in the annual reports of the Louisiana State Board of Health for 1882 and 1883 and in the Proceedings of the Louisiana State Medical Society for 1852. Reference is made in these sources to a second report[18] from the Society for the year 1819, as well as to " . . . a most interesting, precise analitique of the labors of the same society, August, 1817 to January, 1818."

THE FIRST PHYSICO-MEDICAL SOCIETY OF NEW ORLEANS

The second organization of physicians in Louisiana was incorporated in 1820 under the name of the Physico-Medical Society of New Orleans, and, like the French society, had a checkered career. It lapsed into inactivity in 1821, although it continued to exist until 1838. It was reorganized in 1844 and thereafter was fairly active until 1860 or 1861.

It must be borne in mind that the first medical society in New Orleans was composed chiefly of physicians of French descent, although a large number of Americans of English extraction had by this time migrated to Louisiana. They found themselves out of place, naturally, in an organization in which French was the spoken language, and for this reason the Physico-Medical Society of New Orleans, which was incorporated February 16, 1820, was composed chiefly of English-speaking physicians. The first section of the Act[19] of incorporation reads:

"Sec. 1. Be it enacted by the Senate and House of Representatives in general assembly convened, that William Rogers, R. Davidson, L. Harmon, G. C. Forsyth, J. G. Purnell, G. Marshall, S. Alexander, W. W. New, J. S. Vancourt, J. Rice, D. Holt, Colls, J. E. Kerr, J. M. S. Conway, W. N. Mercer, and R. C. Randolph, and others of the said society, shall from and after date of passing this act be, and they or their constituted a body politic, and in deed and in law, which shall be entitled the 'Physico-Medical Society of New Orleans.' "

The constitution of the new society provided for fellows, who were to be elected from among physicians and "other literary persons" residing in the vicinity, and for corresponding members, who apparently answered the same qualifications but were non-residents. Meetings were held on the first and third Saturdays of every month, at 6:30 p. m., from November to May and monthly during the remainder of the year, at 8 p. m. Article 6 of the constitution[20] reads: "At these meetings some subject relating to the medical sciences, or a dissertation on the topics connected with medicine shall be read and defended by the author."

Like their French confrères, the physicians of this society turned their attention to yellow fever and one of their first efforts was an analysis of the epidemic of 1820.

What the society did between its organization in 1820 and the year 1838 is not clear. Even so prolific a writer as Dr. Joseph Jones apparently does not know, for he mentions the organization of the group and then has nothing further to say of it until 1838, for which year he lists the following officers and members:[21]

"Dr. R. Davidson, president; Dr. J. S. McFarlane, vice-president; Dr. J. Harrison, corresponding secretary; Dr. J. M. W. Picton, recording secretary; Dr. J. O. Meux, treasurer; Dr. Thomas Hunt, curator. Fellows—Drs. F. Holt, J. Rice, E. H. Barton, E. B. Harris, C. F. Snowden, F. Beatty, J. S. Crockett, A. Davezac, J. M. Mackie, G. W. Campbell, J. J. Ker, S. W. Ruff, Farrell, G. Bettner, V. Carey, L. Labatut, W. Rushton, J. Jones, W. Stone, W. Wilcox, Kittridge, J. J. Osborne, Palmer, J. U. Landreaux, J. Galerido. Associates—Dr. O. C. Ker, Dr. James Warren, Rev. T. Clapp, Dr. Wheaton, General E. W. Ripley, L. S. Parmley, Hon. F. L. Turner. Corresponding members—New York—Drs. Mott, Francis, Pascalis; Philadelphia—Drs. Parish, Chapman, Patterson; Boston—Drs. Warren, Jackson; Lexington, Kentucky—Drs. Caldwell, Dudley; Ohio—Drs. Drake, B. C. Marshall; Baltimore—Drs. Potter, Davidge; New Haven—Dr. Ives; Portland—Dr. Thatcher; Virginia—Drs. Wilford, Brown, Buck; District of Columbia—Dr. H. Hunt; Mississippi—Dr. Randolph; Au-

gusta—Dr. Toolsom; Louisiana—Drs. J. D. Smith, French, Forsyth; U. S. Army—Dr. Harvey; Alabama — Drs. Levert, Fearn, Mecklin; France—Drs. Chevrin, Gerardin."

THE SECOND SOCIÉTÉ MÉDICALE DE LA NOUVELLE ORLÉANS

In fact, after 1821 both French and English societies seem to have languished for a period of years. Yellow fever, the chief reason for the organization of both groups, was temporarily in abeyance, and nothing else developed to inspire their further activity. Matters continued in this state until 1835, when the Société Médicale de la Nouvelle Orléans was again incorporated by the Legislature, this time for a period of 18 years, with the following members:[22] F. Formento, E. Fortin, Puissan, J. M. Picton, F. Grandramps, A. Delpouch, S. L. Biamonti, H. Bonnabel, A. Byrenheidt, S. W. Dalton, L. Deloche, J. Dufilho, E. B. Harris, M. Halphen, L. Gomatis, J. Labatut, A. P. Lambert, L. Landreaux, T. Leger, J. Lemonier, J. Martin, F. Plaix, W. Rushton, D. Senac, and Thomas T. Ticou.

The act of incorporation provided for the appointment of two physicians to serve in an advisory capacity in regard to the sanitary police of the city, at the disposition of the Mayor and City Council, and also provided that the "Society keep in the City of New Orleans a depot for vaccine matter" to be furnished to the physicians for the State of Louisiana. It will be recalled that from 1835 to 1841 the city had no Board of Health, which makes clear the necessity for such public services from the members of the society.

From its reorganization in 1835 until the year 1839 nothing is available concerning the activity of the reorganized French society. In that year the first medical journal ever published in the city was founded under the name "Journal de la Société Médicale de la Nouvelle Orléans", though unfortunately it lasted less than a year, being discontinued then either because of lack of interest or lack of funds. Copies are exceedingly rare, and no library, so far as can be ascertained, has the complete file.

For a brief period the French society seems to have been fairly active. The index of the Journal lists a report made before the group on the yellow fever epidemic of 1837,[23] and Charles Deléry, in his "Précis historique de la fiévre jaune Nouvelle Orléans" mentions a memoir by Bahier, Martin, Daret and Fortin which was also printed in this journal.[24] When the journal was discontinued, however, the activities of the society which sponsored it also came to an end, and until the second reorganization in 1859 the Société Médicale de la Nouvelle Orléans ceased to exist.

The period immediately following 1839 was a very gloomy one in the medical annals of New Orleans. The medical college was languishing. It had never had a suitable building and the enrollment had never exceeded 35 or 40 students. No medical journal was published. The Physico-Medical Society, wrote Dr. Logan, "was asleep," and the French-speaking medical society had ceased to function.

THE LOUISIANA MEDICO-CHIRURGICAL SOCIETY

Largely through the efforts of Dr. C. A. Luzenberg a new medical society was organized in 1843 and was incorporated April 1 of that year as the Louisiana Medico-Chirurgical Society (Société Médico-Chirurgical de la Louisiane) in the following act:[25]

"Sec. 1. Be it enacted by the Senate and House of Representatives of the State of Louisiana, in general assembly convened:—That Doctors J. F. Beugnot, H. Tricou, C. de Valletti, U. Landreaux, P. A. Lambert, J. Labatut, Dowler, Puissan, Harlan, Mercier, Dupas, Barbe, Thomas, C. A. Luzenberg, J. G. Osborne, H. Lewis, John Rhodes, Slade, Easton, Davezac, Hester, Ridgely and E. D. Fenner and all other persons who may be legally, hereafter, associated with them be and they are hereby created a body corporate under the title 'The Louisiana Medico-Chirurgical Society'."

The Society held its first meeting April 13, 1843. At this time it adopted a constitution and by-laws, and elected its officers, which was not a very simple matter, for it was composed of both French and

English physicians. Dr. C. A. Luzenberg, who was bilingual in addition to his other qualifications, was unanimously chosen the first president.

The Louisiana Medico-Chirurgical Society is in a sense the first state medical society, for every licensed physician and surgeon in Louisiana was, *de facto*, a corresponding member. The resident membership consisted of physicians and surgeons living in New Orleans and the adjacent city of Lafayette (now a part of New Orleans and not to be confused with the present city of Lafayette, in Lafayette Parish).

There still being no Board of Health in New Orleans, the General Council invited the new society to take charge of the sanitary interests of the city, and nine members were appointed, with full powers to act as health commissioners. The Society was also bound "whenever required by order of any Court of Justice, within the cities of New Orleans or Lafayette, to make toxicological examinations," and to make a faithful report of the same in writing.

Early in 1844, Dr. E. D. Fenner and Dr. A. Hester founded "The New Orleans Medical Journal," which has had an almost continuous existence to the present time, being suspended only during the war years in the sixties and for two or three years in the seventies. Shortly after its founding the name was changed to "The New Orleans Medical and Surgical Journal," which title it has borne ever since except from 1868 to 1870, when it was known as "The New Orleans Journal of Medicine."

The new journal reported that at the first anniversary meeting of the Louisiana Medico-Chirurgical Society in April, 1844, the Governor of the State and the President of the Senate were among the honored guests. There was a general feeling that the organization of the society, with its provision for friendly and social intercourse between French and American physicians, was an excellent thing, and for several years the group was very active.

Among the papers presented in these years was one by Drs. William G. Williams and James Andrews dealing with the yellow fever which prevailed during the autumn of 1843 at Rodney, Mississippi. Other reports on yellow fever were made by Dr. P. A. Lambert (in French) and Drs. C. de Valetti and Thomas M. Logan, the latter dealing with a recent epidemic at Woodville, Mississippi. A case of Malis Oestri in the human subject was reported by Thomas Peniston, M. D.

In 1846 the society offered a gold medal, of a value of one hundred dollars, for the best essay on "Strictures of the Urethra, with Their Treatment." The essay could be written in either French or English and was to be presented to the president of the group not later than February 1, 1847. Only two essays seem to have been received by the first Wednesday in April of that year, when another anniversary meeting was held, and the award was deferred to February, 1848. Whether it was ever presented is not known, for after 1847 the society ceased to function actively.

Dr. Thomas M. Logan,[26] writing in 1849, deplored the cessation of the activities of this society, as follows: " . . . since the anniversary meeting of 1847 the Medico-Chirurgical Society has languished until it has fallen into complete decay. It has done no scientific business for two years past, and as if with the view of giving it the coup de grace and terminating its agonies, a small number of members less than a legal quorum, recently got together, gave away its funds, and adjourned sine die. Thus the Society may be said to be dead."

Dr. Logan's appeal to preserve the funds and archives for the nucleus of a future organization apparently went unanswered and the third medical society of the state ceased to exist after six years, four of which seem to have been filled with activity.

THE SECOND PHYSICO-MEDICAL SOCIETY OF NEW ORLEANS

Meantime the Physico-Medical Society, which had been inactive since 1838, had been reorganized December 1, 1844,[27] with a new constitution and the following officers: Dr. Thomas Hunt, president; Drs. Picton and J. O. Meux, vice-presidents; Dr.

C. F. Snowden, corresponding secretary; Dr. A. F. Axson, recording secretary; Dr. G. W. Campbell, treasurer; Dr. W. W. King, curator.

From all accounts, this society was the most active of all of the early medical organizations. It held semi-monthly and monthly meetings, which were apparently well attended by the regular members, medical students, and other invited guests. The meetings were held at the Medical College on the first and third Saturdays from December through May and once a month through the remainder of the year.

The programs consisted of three parts: (1) An essay on some subject in medicine or natural philosophy; (2) the discussion of some set question; (3) observations by each member on the diseases of the day. Interesting accounts are available of some of the discussions and reports. In February, 1845, for instance, a Dr. Hort[28] read an article dealing with quarantine laws. On motion of Dr. Farrell it was turned over to a committee of five members (Drs. Farrell, Hort, Jones, Axson and Dowler) appointed by the president, who at the following meeting summed up its principal conclusions, as follows:

"1. That they believed that yellow fever was of local or domestic origin.

"2. That it is not an imported disease.

"3. That it is not contagious . . . .

"8. That there is no occasion for quarantine laws. That experience has shown them to be useless here, while they would be very expensive, highly injurious to our commercial interests, and onerous to the passengers."

In 1849, for the first time, delegates from Louisiana were sent to the Convention of the American Medical Association, which was held in Boston May 1. At the meeting Professor James B. Jones, one of the delegates, who was a member of the Medical Department of the University of Louisiana, was nominated to the Committee on Practical Medicine, and Dr. J. C. Simonds. the other delegate, was elected to the Committee on Hygiene.

At the anniversary meeting in 1850 Dr. Hunt was re-elected president. Other officers elected included Drs. Farrell and Bein, vice-presidents; Dr. J. C. Simonds, corresponding secretary; Dr. Howard Smith, treasurer; Dr. J. A. Nott, curator; Dr. Macgibbon, recording secretary; Dr. E. D. Fenner, orator.

During this year a committee was appointed to study epidemic colic, which had made its appearance for the first time during the summer, and the report was read by Dr. E. D. Fenner. A committee composed of Drs. Jones, Riddell and Axson, which was appointed to study the subject of lead poisoning, later reported that lead was found in carbonated water but not in river water. According to the Annual Report of the Board of Health of New Orleans and Lafayette for the year 1850 the Society again supported the report of Dr. Harrison, which had previously been recorded in its transactions, "in regard to the practice of warding off the deadly assaults" of yellow fever.

The anniversary meeting in 1851 was celebrated with an appropriate oration by Dr. E. D. Fenner, the duly elected orator. Dr. Farrell was retained as one of the vice-presidents, Dr. Macgibbon as recording secretary, Dr. Simonds as corresponding secretary, and Dr. Nott as curator. Dr. James Jones was elected president and Dr. Bein was one of the vice-presidents.

At a meeting held October 2, 1852, Professor J. L. Riddell demonstrated the binocular microscope which he had devised and manufactured and which was to prove later of untold advantage to science. At other meetings of this year the society investigated a case of "fatal poisoning from sugar plums," and passed a resolution on the death of Daniel Drake, M. D., and at the last meeting elected Dr. A. F. Axson president.

In 1854 Dr. R. Bein was president and a Dr. Chappin vice-president. At the January 7 meeting Dr. Fenner reported a case of thrombus occurring in a negro woman after delivery of her first child. At the February 4 meeting Dr. Thomas Hunt re-

ported a case of paralysis of both upper and both lower extremities. At the same meeting Dr. Axson reported several cases of scarlet fever, Dr. Meux a case of tetanus, Dr. R. Gale several cases of severe diarrhea, and Dr. Chappin two cases of measles. Later in the same year reports were heard on cases of measles, diarrhea, dysentery, scarlet fever, neuralgic cholera, and urethral stricture, as well as a case of imperforate anus which had been entirely relieved by surgical treatment at Charity Hospital.

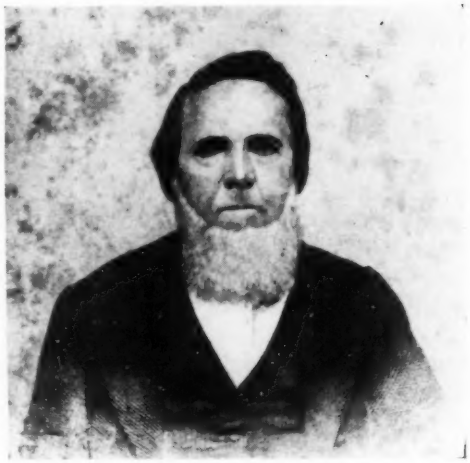
At the anniversary meeting in December, 1854, Dr. A. Mercier delivered the oration and deplored, among other things, the lack of progress in medicine as compared to surgery, though this was long before the days of Pasteur and Lister. The activities of the society seem to have ended in 1858, with a discussion of the radical cure of inguinal hernia. Why so active a group should have so suddenly ceased to function is not clear.

(*To be continued*)

SAMUEL A. CARTWRIGHT AND STATES' RIGHTS MEDICINE*

MARY LOUISE MARSHALL†
NEW ORLEANS

As one of the most colorful figures of Southern medicine in the first half of the last century, it is surprising that so little present-day recognition has been accorded Dr. Samuel A. Cartwright, of Natchez and New Orleans. In a day when medical journals were few, he published more than eighty articles** before his death in 1863; his physiologic experiments on the Louisiana alligator attracted much attention and controversy; his therapeutic innovations were marked by originality, and his opinions were noted as befitted his reputation for medical learning and experience.



SAMUEL ADOLPHUS CARTWRIGHT
(1793-1863)

Samuel Adolphus Cartwright was born in Fairfax County, Virginia, on November 30, 1793. He was the son of Rev. John S. Cartwright and came of a family of poets, scholars and inventors. Being determined to become a physician, he began to study medicine under the supervision of Dr. John Brewer, in his native county, but his studies were interrupted by the War of 1812, in which he enlisted. In the Battle of North Point, while serving in Tanson's artillery, he received an injury which resulted in a slight deafness that became progressively worse until his death.

Leaving military service after his injury, he resumed his medical studies, in the office and under the direct supervision of Dr. Benjamin Rush. He left, however, before receiving his degree from the University of Pennsylvania, to begin practice in Huntsville, Alabama. In one of his articles he refers to some years of study in Maryland, probably in Baltimore, for it was from here here that one of his most signal honors was conferred upon him.

In 1822, he moved to Natchez, Mississippi, and the following year he won a prize of-

*Read before the Orleans Parish Medical Society, March 11, 1940.

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**The author wishes to express to Dr. Rudolph Matas her grateful appreciation for the privilege of consulting his bibliographic notes, compiled in the preparation of his History of Medicine in Louisiana.

fered by the American Medical Recorder for an essay on the Epidemic Fever of Monroe County, Mississippi, in the summer and autumn of 1822. It is probable that his observations on this epidemic were made while he was en route from Huntsville to Natchez; he may have remained in Monroe County for several years, but there is no record of extended practice there.

Dr. Cartwright was a Latin and Greek scholar of some years, and he now studied French. He took his examination before the Western Board of Medical Censors and received his license to practice in this extensive area.

Within a year or so after he moved to Natchez, he contracted yellow fever. He was cared for by the Rev. Mr. Burruss, in a laundry shed near Mr. Burruss' home, about a mile and a half from Natchez, directing his own treatment. None of the family contracted yellow fever and Dr. Cartwright attributed this to cleanliness, fresh air and careful nursing.

In 1825, he married Mary, eldest daughter of Dr. Woodson Wren. This same year occurred another disastrous yellow fever epidemic and this siege is said to have afforded Dr. Cartwright and "his life-long friend, Dr. John W. Monette, their first opportunity to acquire distinction in their profession." A contributor to DeBow's Review says: "They soon placed their reputations among the best contributors to the medical literature of the day, secured for them both a practice always lucrative, which it is believed never waned while they chose to attend it."

At this time was published his "Essay on Syphilis," introducing in this country the use of large doses of calomel in its treatment. The following year he published two prize essays. The first, an ambitious study of some 84 pages dealt with the causes, symptoms, morbid anatomy and treatment of some of the principal diseases of the Southern states, the first of many on this subject. Dr. Cartwright believed that in a climate so different, the aspect of many diseases varied from the normal; in addition, there were many diseases encountered in the South, which physicians in the North were never called upon to treat. For this reason, he sponsored the education of Southern medical students by Southern physicians in their own locale, and became known throughout the medical world of his day as a specialist in the diseases of the South.

In 1826, he published an essay on "Cholera Infantum," for which he received a prize of one hundred dollars from the Medical and Chirurgical Faculty of Maryland. In this year also, a gold medal was awarded to him by the Boylston Medical Committee of Harvard University for his dissertation on "Whether the Veins Perform the Function of Absorption."

It is not surprising that Dr. Cartwright's knowledge of the diseases peculiar to his locale should have reached the attention of Dr. Daniel Drake. His article on the use of iodine in certain infections occurring in the South is reviewed in the Western Journal of Medical and Physical Sciences, edited by Dr. Drake, and Dr. Cartwright is referred to as "an ingenuous and indefatigable physician." In 1827, the American Medical Recorder comments editorially on his "valuable discovery respecting the diseased state of the ganglions and nerves from the spinal marrow."

His surgical contributions, though few, are interesting. In 1829, he reports in the Transylvania Journal of Medicine, a case of epilepsy cured by operation with a trephine; and in 1832, he announces a contrivance for use in wounds of the lung, empyema and dropsy, to drain the "thorax of liquid, at the same time excluding the admission of air." This latter observation received notice in the London Medical Gazette.

In 1832, a terrible cholera epidemic broke out and Dr. Cartwright was again in the front of the fight. He was unusually successful in the treatment of Asiatic cholera and his written observations were quoted widely in this country and abroad. He was offered professorships in Boston, Philadelphia, St. Louis, and Baltimore, but he preferred to remain in the far South. In 1834, certain citizens of Pine Ridge, Adams Coun-

ty, Mississippi, presented Dr. Cartwright with a "splendid vase with suitable inscription" and one thousand dollars as a testimonial of their sense of his eminent services in the year 1833 during the prevalence of cholera.

Having accumulated a handsome fortune, in 1836, he went with his family to Europe for eighteen months' travel in France, England, Italy, and Switzerland, where he was received most cordially, studying and attending clinics throughout his trips. His treatise on yellow fever was adopted by the French Government. While in Paris, undergoing a course of treatment for his deafness, Dr. Cartwright was called home by the failure of the New Orleans firm which cared for his fortune. He returned to Natchez and spent the following ten years in arduous practice, with a three months' tour of the North in 1847 for the benefit of his health and to gather new medical information.

During this second period of active practice in Natchez, Dr. Cartwright made several interesting observations: First, an article on the health preserving properties of the Jussiere grandiflora, or floating plant (1840), which is reprinted in full in Daniel Drake's Principal Diseases of the Interior Valley of North America. He based his proof on the fact that the plant purified the waters on which it grew, and notes the remarkable exemption of the inhabitants of the surrounding area from malaria and miasmatic diseases. Mississippi had at this time annulled its laws regulating medical practice and in another report, Dr. Cartwright by statistical analysis shows the resulting enormous increase in mortality. In 1846, before the medical convention in Jackson, Mississippi, he argued in favor of organization against quackery and patent medicines and for Southern diseases to be studied and treated by Southern doctors. In 1842, he presented, before the Natchez Medical Society, a synopsis of medical etiquette which was unanimously adopted by that organization and indeed merits recognition by the medical profession of today.

From this time on, Dr. Cartwright began to confine his study and writings to Southern diseases and Southern therapy, and was severely criticized for his ideas in this regard by Dr. John Bell who was responsible for naming him the sponsor of "states' rights medicine." Dr. Cartwright warmly answered Dr. Bell's attack before the Mississippi Medical Convention in 1846.

In 1848, he came to New Orleans to study cholera in the Charity Hospital and to witness a great number of autopsies on cholera subjects. He decided to remain in New Orleans and continue his practice in this city, and, in 1849, published a small pamphlet entitled "Pathology and Treatment of Cholera, with an Appendix Containing Latest Instructions to Planters and Heads of Families"; this publication was widely reviewed. In view of the present knowledge of the transmission of cholera his advice to planters is interesting: "Remove the sick and well to a new locality immediately on the appearance of the disease. Cholera poison follows a road, river, hedge or ditch and has a tendency to rest in houses whether inhabited or not." The Boston Medical and Surgical Journal observed: "Such is the reputation of Dr. Cartwright for both professional skill and learning that this publication is unquestionably exerting a commanding and sanitary influence in the region of the country for which it was prepared." The editor of the New Orleans Medical and Surgical Journal says: "Dr. Cartwright is extensively known throughout the South as an able writer and medical philosopher. He has written much and well on political as well as on medical subjects, and in both departments he wields a ready and an able pen. In starting new issues or in sustaining old ones, he is equally original and maintains his position with inflexible firmness and illustration. . . . His opinions have great weight with the public on all subjects connected with medicine. He has been for nearly half a century a practitioner of medicine in the South where he has enjoyed extensive opportunities for studying our peculiar diseases." The political writings referred to sponsor the South's attitude toward slavery, which Dr. Cartwright

argued was justified both ethnologically and on Biblical authority.

In 1851, he was appointed Chairman of a Committee of the Medical Association of Louisiana to report on diseases of the negro. This study also stresses the importance of the study and treatment of diseases in the South by physicians trained in this locality. He became Professor of Diseases of the Negro, in the Medical Department of the University of Louisiana—later Tulane University of Louisiana School of Medicine. So far as can be ascertained, this is the only Professorship in Diseases of the Negro ever established in any American medical school.

The following year a series of articles appeared in which Dr. Cartwright upheld Mrs. Emma Willard's theory that the motive power of the blood lay in the lungs rather than in the heart. His arguments, backed by experiments on the Louisiana alligator, were described in his most argumentative style. Of his controversial talent, Dr. D. Warren Brickell, of New Orleans, says in a contemporary editorial: "Dr. Cartwright is not easily driven from the field of controversy, and if modern writers fail him, he appeals at once to those who write in Greek, Latin and Hebrew, thus overwhelming his assailants by his immense Biblical knowledge. Let no critique then attack the doctor without first counting the cost. He wields a club of Hercules and never lifts it but to fell his opponent to the earth."

Perhaps the most interesting of Dr. Cartwright's endemic remedies was his so-called sugar-house cure for bronchial, dyspeptic and consumptive complaints, propounded in 1852. Through long years, he had observed the appreciable gain in weight of all those employed in cane grinding and the local refining of sugar. Applying this observation to practical therapy he assigned patients suffering from bronchial and pulmonary complaints to spend their days on a platform built over the kettles of boiling cane in the sugar houses of South Louisiana plantations. The patients gained in weight and the cough was much improved, at least temporarily. Unfortunately the treatment received newspaper publicity in the North and Dr. Cartwright was sadly misquoted. This brought forth a series of articles justifying his therapeutic suggestion before the medical profession with testimonial letters from the patients so treated.

Dr. Cartwright was strongly opposed to the use of alcoholic beverages and published a study based on his own experience of longevity in connection with the use and abuse of alcohol. Many of his later articles deal with the diseases and constitution of the negro and diseases to be found principally in the South. An interesting communication in 1860 describes the virtues of the hot springs of Arkansas. A number of letters and reports, political in tone, deal with the South's attitude toward the negro, and bespeak the troublous times just preceding the War between the States.

Dr. Bennet Dowler and Dr. Cartwright seem to have been warm friends. One of Dr. Dowler's physiologic contributions is dedicated to "Samuel Cartwright, M. D., distinguished as a philosopher, honored as a physician, admired as a man." Referring to Dr. Cartwright in 1857, he said: "It is not the man who has practiced medicine most extensively and has obtained thereby most wealth; but he who transmits to his successors the rich stores of his experience, observation and thoughts in the art of healing, that deserves to be called philanthropist and philosopher."

His health preventing active service, shortly after the outbreak of the War between the States, Dr. Cartwright received an appointment to care for the health of the Confederate soldiers in the Natchez area, and while on duty here he contracted the disease which caused his death in 1863.

Perhaps we are inclined to honor too little the physicians of the last century. Working without laboratory facilities as we know them, without knowledge of asepsis and x-ray, without libraries other than their personal collections, small wonder that some of their conclusions were incorrect. The wonder is rather that they observed and accomplished so much under the very difficult conditions of medical practice in their day. The records of their work, which are

left to us, show unusual earnestness, sincerity, ingenuity and originality. Outstanding in all these attributes was Samuel Adolphus Cartwright. Recognition for his distinguished accomplishments was given him in his own time, and no less appreciation should be accorded him in our day, as a pioneer of medicine in the deep South.

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ACUTE ASEPTIC MENINGITIS*

A DISCUSSION OF THE ETIOLOGY, EPIDEMIOLOGY AND DIAGNOSIS

JOSEPH G. PASTERNACK, M. D.†
NEW ORLEANS

Meningitis is an alarming disease. The signs and symptoms are clinically more or less the same irrespective of the cause, and depend mainly on the intensity and extent of the inflammation of the meninges. If there is a meningitis present, it is important to determine the cause. This is essential from the point of view of therapy and especially the prognosis.

In 1924 Wallgren[1] called attention to a peculiar form of meningitis that he termed acute aseptic meningitis. Most of his patients were children and young persons. After mild prodromal symptoms of short duration, the patient became acutely ill, often with high fever, headache, vomiting and more or less stupor, but rarely complete unconsciousness.

Examination regularly disclosed stiffness of the neck, positive Kernig's sign, decided opisthotonus and slight or no localizing symptoms referable to the central nervous system; at most only sluggishness of the pupils, anisocoria, perhaps strabismus, rarely paresis of other cranial nerves, for example the facial. The spinal fluid was clear or occasionally turbid, under slightly increased pressure and with elevated globulin and cell count. The cells were usually lymphocytes, with some polymorphonuclears occasionally present early in the disease. The cell count was moderate and rarely around 1,000 or over. Smear and culture failed to disclose the presence of microorganisms. The course of the disease was short and the prognosis was regularly good.

In 1929 Viets and Watts[2] described three cases of Wallgren's disease at the Massachusetts General Hospital. Soon more reports began to appear in this country and in Europe, but without clues as to the etiology.

In 1934, during the transmission from monkey to monkey of infectious material derived from a fatal case of the 1933 St. Louis epidemic of encephalitis, Armstrong[3] encountered a virus that was quite distinct from the virus of St. Louis encephalitis. On the basis of the pathologic picture produced by intracerebral inoculation of monkeys and mice, he named it the virus of experimental choriomeningitis. He predicted that the virus would ultimately be found to have some significance in human medicine. He also stated, that the human disease most nearly simulated by the experimental disease in monkeys was perhaps the so-called "lymphocytic or aseptic meningitis" described by Wallgren, Viets and Watts and others.

Traub[4] later isolated a virus from a colony of apparently normal white mice, which appeared to resemble closely the virus isolated by Armstrong. The isolation of a similar virus from the spinal fluid of two human cases of Wallgren's meningitis by Rivers and Scott,[5] and the proof of the immunologic identity of the viruses isolated by Armstrong, Traub, and Rivers and Scott, has provided evidence for the etiologic agent of one group of cases of "acute aseptic meningitis" or the more descriptive and accurate designation "lymphocytic choriomeningitis."

I wish to point out now that the outstanding authorities on this disease[5, 7, 8] have presented evidence that all cases of acute aseptic meningitis are not caused by this virus and that the clinical entity described by Wallgren has more than one etiologic agent or agents.

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*Read before the sixty-first annual meeting of the Louisiana State Medical Society, New Orleans, April 22, 1940.

†From the U. S. Public Health Service, Marine Hospital, New Orleans.

It is difficult or impossible to differentiate by clinical means alone, the cases of acute aseptic meningitis caused by the virus of lymphocytic choriomeningitis, from those in which no causative agent can be demonstrated; however, according to the report of Baird and Rivers,[9] the spinal fluid cell counts in the cases studied by them were higher in the former group than in the latter.

The virus of lymphocytic choriomeningitis has now been recovered in several widely separated places, in the United States, in Europe and in Japan.

The method of spread of the infection has been an important subject of investigation. Wooley, Armstrong and Onstott[6] were able to transmit occasional infection by instilling the virus into the urethra or vagina of monkeys. These observations together with the fact that they had demonstrated the virus in urine, where it tends to persist, and in the seminal vesicle fluid and testicular tissue of infected animals, suggested to them a venereal route as one of the possible explanations for the transmission of the disease in adults.

The virus is known to spread spontaneously among monkeys and mice, and it may be endemic in animals over a period of years.[10] Traub[10] has shown that naturally infected mice, capable of transmitting the disease, generally discharge large amounts of virus through the nose for a longer period of time than mature mice experimentally infected. In addition to contact infection, pregnant mice that continued to carry virus in the blood after clinical recovery, often transmitted the virus to their embryos.

Only recently Armstrong and Sweet[11] reported finding active choriomeningitis virus in three of five mice trapped in two houses in which proved human cases of the disease were present. They failed to find the infection in 21 mice trapped in eight houses and buildings in which the human disease was not present. This association of human cases and infected mice is more than a coincidence.

Coggeshall[12] reported the transmission of the disease to guinea pigs by the bite of *Aedes aegypti* mosquitoes. He stated that they can transmit the infection as early as the fourth and as late as the fifteenth day after feeding on an infected animal. The study is being extended to include other hosts and vectors.

It is interesting to note that the infection of workers constantly in contact with infected animals is rare and there are but few instances in which neutralizing antibodies were demonstrated in workers.[13]

It is more probable that the usual source of infection for man is man. In this connection it is important to mention that MacCallum and Findlay[14] recovered the virus from the nasopharyngeal washings of a patient on two occasions early in the disease.

With increasing reports of human cases of aseptic meningitis in this country and in Europe, it was but natural that epidemiologic studies should follow in an endeavor to determine the prevalence of infections with the new virus. These studies have been based largely on the detection of virus neutralizing antibodies in the serum of persons recovered from the disease.

Wooley, Armstrong and Onstott[6] tested the blood sera of 1,248 persons from varicus localities in the United States for protective antibodies against the virus of lymphocytic choriomeningitis. They demonstrated antibodies in 138, (11 per cent), questionable protection was obtained in 131 (10.4 per cent), while 979 (78.6 per cent) gave negative results. Fifty-three of the 1,248 sera were from clinically diagnosed cases of "aseptic meningitis." Antibodies were demonstrated in 17 of the 53 sera (32 per cent). They demonstrated antibodies in 117 sera from 997 persons without any history of central nervous system or meningeal involvement.

Wooley, Stimpert, Kessel and Armstrong[15] studied 680 blood sera from persons in various localities of the United States, Hawaii, Panama, Canal Zone, and Puerto Rico. Of the total number, 18.1 per cent definitely showed protective antibodies, and the areas represented showed widely divergent results. Thus, in the larger

groups the proportion showing protection varied from 6.3 per cent in the Middle Atlantic States to 44.3 per cent in the Pacific States. However, all areas from which a reasonably large number of bloods were examined showed some virus neutralizing sera. These findings, together with those already reported, emphatically suggest that the infection is widely distributed and infects man more commonly than is generally believed.

The investigations mentioned disclosed that many individuals without histories of having had any involvement of the central nervous system possessed neutralizing antibodies in their blood against the virus of lymphocytic choriomeningitis. Thus, it appears that a person can be and not infrequently is infected with this virus without having had any illness referable to the central nervous system.

The variability in severity of proved cases of the disease in man, and the often observed presence of a "cold" or "grippe" a few days prior to the occurrence of meningeal symptoms suggests that these early signs may represent a systemic invasion in which meningeal involvement is a later and possibly exceptional occurrence. The high incidence of virus neutralizing antibodies found in persons giving a history of upper respiratory infection but no meningeal involvement supports this view. Also, this concept is compatible with the experimental disease in animals inoculated with the virus by routes other than directly into the central nervous system, and with the results of Lepine,[16] Laigret and Durant,[17] and Kreis[18] in the inoculation of human volunteers.

A significant but unexplained observation is that although the majority of cases of acute aseptic meningitis have been in children and young indviduals, the serologic evidence of asymptomatic infection in children is slight.

The epidemiology of lymphocytic choriomeningitis is still in the embryonic stage. Spontaneous epidemics of this disease are known to occur in stocks of monkeys, and colonies of mice. Small epidemics have been reported in man. The epidemic reported by Kent[19] in a large group of children unfortunately lacks the important data essential in establishing a diagnosis.

The disease appears to be most prevalent in the summer months, June, July and August; cases also occur in March, April and in September. It is definitely not a winter disease. Cases may occur in the same family or in children in the same classroom. On clinical and epidemiologic evidence, there is the danger that the disease may be considered an abortive form of poliomyelitis.

From the clinical data and the extensive experimental studies, there is no evidence that the virus of lymphocytic choriomeningitis involves any part of the nervous system except the meninges and choroid plexus. Hence signs of a meningitis are the sole clinical manifestations of its activity.

On the other hand many viruses that attack the central nervous system also produce some reaction in the meninges, but in addition there is definite injury to some particular part of the brain or spinal cord with a resultant train of symptoms and signs considered to be more or less characteristic, that is, selection of the anterior horn cells in poliomyelitis and the nuclei of the cranial nerves in encephalitis. However, it should be remembered that signs of meningitis may be the only clinical manifestation of abortive attacks of poliomyelitis, of the St. Louis type of encephalitis, or of epidemic encephalitis in its meningeal form. Moreover meningeal signs may occasionally be the outstanding feature of other virus diseases, such as herpes zoster and mumps. The disease has been frequently diagnosed tuberculous meningitis. The danger of confusng lymphocytic choriomeningitis or Wallgren's disease is so great, that extreme caution must be exercised in giving a prognosis in cases of meningitis until every means to determine the etiologic agent is used in each case.

Lymphocytic choriomeningitis in man is usually a benign, acute, transient disease. Occasionally it may be subacute or chronic,

prolonged and severe, but rarely, fatal. Two fatal cases have been recorded.[20, 21] Sequelae are rare. One case of adhesive arachnoiditis[22] and one of mental deterioration[23] have been reported.

SYMPTOMS

The transient form usually has an acute onset without distinct prodromal symptoms, or with those of a "cold", the "grippe" or one of the acute infectious diseases. It begins with headache and a feeling of dizziness. Soon drawing pains appear in the muscles of the neck, the back and the legs. The headache becomes severe and the patient desires to go to bed. A mild degree of fever is present. Rarely the patient complains of chilliness. All patients complain of nausea, and in about half of the cases there is associated vomiting. The patient is frequently ill several days before the physician is called, and by then meningeal signs and symptoms are usually present. There is fever, stiffness of the neck, severe headache, and Kernig's sign is present. There may be retention of urine, stupor, delirium, convulsions, aphasia, blurred vision and transient paresis of the facial or ocular nerves. There may be a positive Babinski sign. There is frequently a pharyngitis or tonsillitis.

Examination of the cerebrospinal fluid is important. The pressure is normal or slightly increased. The fluid is usually water clear, occasionally opalescent and rarely a fine web or pellicle may form after several hours' standing, a finding traditionally associated with tuberculous meningitis. The cell count shows wide variations. The total cells may be less than 100 and all lymphocytes, or as high as 12,500 and 70 per cent polymorphs.[24] Polymorphonuclear leukocytes are frequently associated with severe illness. Their reduction in number and final disappearance is stated to be coincident with recovery. The total protein is frequently increased and may be double the normal. The colloidal gold test may be normal or show a meningitic reaction. Some authors[2, 25] stress the normal sugar and chloride content in the spinal fluid as being of diagnostic significance in differentiating between lymphocytic choriomeningitis and tuberculous meningitis. This finding however, loses its significance when there is severe vomiting and the spinal fluid chlorides and sugar may be lowered in lymphocytic choriomeningitis to the level found in early tuberculous meningitis.[26] The complement-fixation test for syphilis is negative. Micro-organisms cannot be demonstrated in smears and cultures of the spinal fluid. The blood may show only a minor leukocytosis on a count of 20,000 with an absolute lymphocytosis.

COURSE

The course of the acute transient form varies in severity and duration, but most patients recover in one or two weeks. The fever may be up to 104° F. the first day or two, but this rapidly abates and a temperature of 99° to 100° F. continues eight to 11 days and then there is a return to normal by lysis. Occasionally a low grade fever may persist for two weeks. The cells in the spinal fluid return to normal and the muscle stiffness in the neck disappears. The more severe symptoms, such as coma and convulsions, usually disappear after the first or second withdrawal of spinal fluid. In some cases stupor or coma may persist for a week and death may seem near, then suddenly the symptoms abate.

Occasionally after a few days or a week there may be a relapse, but the symptoms are usually mild and of short duration.

While the majority of cases have been of the acute transient type, a prolonged and severe form of the disease may be encountered. The literature contains but few references to this type of choriomeningitis. Cases lasting three to four weeks, six weeks, two months, four months and five months are on record.[24] Cases of this type may cause considerable concern as to diagnosis and prognosis.

THE CHRONIC FORM

The chronic form may be a continuation of the acute disease, but more often it is insidious in onset. Headache is a constant complaint. Drawing pains in the muscles of the neck and back are usually present,

occasionally also in the legs. Meningeal signs and symptoms are rarely pronounced early in the course of the disease. The spinal fluid is regularly under increased pressure. It is opalescent and may show web formation after standing. The cells vary between 200 and 500 and are practically all lymphocytes. In all of the reported cases, after several weeks the fever and symptoms were augmented and became severe. The majority of chronic cases have been in adults. Recovery is the rule and there have been no serious complications or sequelae.

CONCLUSIONS

To prove that a patient has lymphocytic choriomeningitis the virus must be isolated by animal inoculation from the spinal fluid or blood; or virus neutralizing antibodies must be demonstrated in the serum of the patient against a known strain of choriomeningitis virus. There is the possibility that an occasional patient infected with the virus may not develop antibodies. In Howard's case[26] antibodies did not appear until 45 weeks after the onset of the acute infection. While virus neutralizing antibodies have been shown to persist for two or three years, they may disappear after a few months.[9]

The complement-fixation test and precipitin reaction developed by Smadel and his co-workers[27, 28] may prove to be more practical and more useful than the virus neutralization test for the diagnosis of lymphocytic choriomeningitis.

There is no specific laboratory method for the diagnosis of those cases of acute aseptic meningitis that are not caused by the virus of lymphocytic choriomeningitis. They cannot be differentiated by clinical means alone.

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DISCUSSION

Dr. Hugh P. Newbill (New Orleans): Dr. Pasternack's review has been so comprehensive that little is left for me to say. My personal contact with the disease under discussion has been insufficient to draw any significant conclusions.

Four years ago at the University of Virginia Hospital I did observe several patients whose condition was felt to be acute aseptic meningitis; the diagnoses, however, were only reached by a process of elimination. Shortly after they were discharged from the hospital, we learned that a peculiar form of so-called "grippe" was epidemic in the community. A number of patients had complained of severe headache, mild to moderate stiff neck and generalized aching. These symptoms were of short duration and many were not sufficiently sick to have medical attendance. In several instances more than one member of a family was sick. One layman, in social conversation, told me that "nearly everyone I know has had it." The fact that stiffness of the neck was so persistently present made us feel that we actually were dealing with an epidemic of acute aseptic meningitis, only a few cases having been sufficiently severe to warrant hospitalization. Whether or not this was an actual fact, I, of course, cannot say. However, we may safely assume that similar mild or even subclinical cases must occur to account for the relatively widespread degree of immunity to the disease.

In the same community, we saw an unusual number of neurologic patients whose lesions we felt were due to viruses. I would like to ask Dr. Pasternack if there is any evidence indicating that this disease is more common in regions where other virus infections are endemic or epidemic.

Dr. Pasternack: This observation has not been made.

SULFAPYRIDINE THERAPY IN PNEUMOCOCCIC MENINGITIS COMPLICATED BY PULMONARY TUBERCULOSIS WITH RECOVERY

CASE REPORT

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NEW ORLEANS

Hewell and Mitchell,[1] who reviewed the literature of pneumococcic meningitis through 1938, reported that between 1927, when Goldstein and Goldstein collected 150 recoveries, and 1937, thirty authentic recoveries from the disease were recorded in the literature. Between 1937 and the date of writing, they themselves were able to collect 27 recoveries from pneumococcic meningitis in which the administration of sulfanilamide or its derivatives had formed part of the therapy. To this number, they added three personal recoveries and had seen an additional recovery before the paper was published.

From 1926 to 1937, according to these authors, 23 cases of pneumococcic meningitis had been attended with a 100 per cent mortality at the Children's Hospital of Cincinnati and on the children's services of the Cincinnati General Hospital. The introduction of sulfanilamide had reduced the mortality in six cases observed after 1937 to 50 per cent. Data available from personal observation and the literature did not permit any conclusions as to whether better results were secured with sulfanilamide, prontosil, or sulfapyridine. It could not be shown that the age of the patient, the type of pneumococcus, or the dosage bore any constant relation to recovery.

The case herewith reported is put on record for two reasons: First, that it furnishes another instance of recovery from pneumococcic meningitis as the result of sulfapyridine therapy; and second, that the acute meningitic state was complicated by active pulmonary tuberculosis and by a tuberculous infection of the knee joint.

CASE REPORT

F. I., a white girl aged 10 years and 10 months, was first seen December 27, 1939. For the past two years, she had had a painless unilateral (right) synovitis of the knee, with intermittent exacerbations. In the course of the last attack, she had been seen by an orthopedist, who referred her to me for a general examination before instituting any therapy.

The past history was negative except for the synovitis mentioned and recurrent attacks of otitis media, none of which had needed surgical therapy. The child was of normal size and weight for her age, and looked healthy. The only positive physical finding was an enlargement of the right knee, with evidence of fluid in the joint.

Blood study and urinalysis revealed nothing abnormal. A tuberculin test was strongly positive, and roentgenologic examination of the chest was reported as follows:

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Stereoscopic films of the chest show . . . "the right hilus shadow to be somewhat prominent. There is an infiltrative process in the left apex made up of strand-like shadows and a few clearly demarcated interspersed tubercles. The lower portion of the left lung appears to be normal. There is some increase in the markings in the extreme right apex and it is believed that there is a tuberculous infiltration in this area also, though to a lesser degree than on the opposite side. The lower portion of the right lung is clear, and both diaphragms are smooth and well rounded. Serial studies will be necessary to determine the activity of the tuberculous process, which is of the adult type."

Since the child had no temperature elevations, night sweats, loss of weight, or other signs of tuberculous activity, a regimen of only partial rest was instituted. A cast was applied to the right leg, extending from the thigh to the toes, after fluid had been aspirated from the joint. The fluid was proved by guinea pig inoculation to contain tubercle bacilli.

Clinically the child remained perfectly well except for occasional recurrences of the old otitis media. At the end of six weeks, a second roentgenogram of the chest was reported as follows: "Re-examination of the chest (February 13, 1940) with stereoscopic films again shows the tuberculous infiltration in both apices. At this time, there is seen a rounded, discrete nodule of soft tissue density, measuring approximately 1.1 cm. in diameter and lying in the left upper lung field at the level of the first interspace anteriorly and the fourth posteriorly. This lesion was not present on the previous film and the findings suggest a large conglomerate tubercle. No other evidence of extension of the disease is noted. The diaphragms are smooth and well rounded and the costophrenic angles are clear."

The child was immediately put upon a regimen of complete bed rest. She continued well except for recurrent attacks of acute purulent otitis media, for which otolaryngologic consultation was sought. The temperature during these attacks at no time exceeded 99.8°F. A culture of the discharge revealed mixed staphylococci, streptococci, and pneumococci. Neoprontosil therapy was instituted, but was without apparent effects.

February 27, 1940, the child awakened complaining of severe pain in the left ear. The drum was bulging and reddened on the first examination, and a few hours later the process had so advanced that myringotomy was necessary and neoprontosil was resumed. A profuse, purulent discharge was present.

The following day, February 28, there was a complaint of nausea and malaise. By afternoon, the child began to vomit, and the temperature was 103°F. Sulfanilamide was substituted for the neoprontosil, but the vomiting continued. At midnight, a severe generalized headache was relieved by codeine gr. ¼ and aspirin gr. 5.

The following morning, February 29, the temperature was only 101°F., but the vomiting was almost continuous. All medication by mouth was stopped and hospitalization was advised.

Roentgenologic examination of the mastoid and sinus areas immediately after the child's admission to Touro Infirmary revealed the left mastoid area to be cloudy, although no breakdown of the intercellular trabeculae could be definitely demonstrated. Blood study showed 5,200,000 red cells and 14,500 white cells per cu. mm., with 85 per cent polymorphonuclear cells.

Neoprontosil (10 c. c. of 5 per cent solution) was given intramuscularly and 1,500 c. c. of 5 per cent glucose in normal saline solution was given by vein. By 10 p. m., the temperature, which had been steadily rising since morning, was 105° F., and rigidity of the neck was apparent. Spinal tap disclosed cloudy fluid under considerable pressure (300 mm. water). The cell count was reported as 5,050 and the globulin as 3 plus. A stained smear revealed gram-positive diplococci, which were found to be pneumococci, type XIX.

Left mastoidectomy was immediately performed under ethylene anesthesia by the otolaryngologist. As soon as the mastoid cortex was opened, pus oozed out under pressure and there was evidence of a breaking down of the mastoid cells. As the operation progressed, it was observed that an unusual amount of pus under pressure oozed from a point just above the knee of the lateral sinus. Further investigation disclosed a large extradural abscess containing a large quantity of pus. It was necessary to remove considerable bone covering the lateral sinus in order to expose and adequately drain the abscess cavity. The mastoid was well pneumatized and the cells were exenterated as completely as possible. An iodoform gauze pack was placed in the mastoid cavity and another was inserted into the extradural abscess cavity. The mastoid wound was left wide open. The child's condition at the conclusion of the operation was as good as could be expected.

The pus obtained from the mastoid proved to contain type XIX pneumococci, and a blood culture made at the time of operation was reported to contain the same organisms.

Immediately after operation, an infusion of 1,000 c. c. of 5 per cent glucose in normal saline solution was given, following the intravenous injection of 1.9 gm. of sodium sulfapyridine. During the next six hours, following tests for sensitivity, a total of 100,000 units of type specific (pneumococci XIX) rabbit serum was given, also by vein. After the final injection, a chill occurred, which lasted about 20 minutes and was accompanied by cyanosis and a rise in temperature to 104.4°F. The temperature promptly fell to 99.2°F., slightly

lower than it had been six hours after operation (fig. 1).

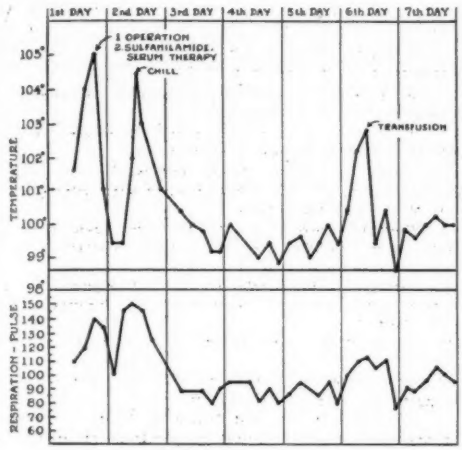

Fig 1. Temperature and pulse for the first six days of the acute illness. Thereafter, the temperature remained normal or approximately normal.

The initial intravenous dose of sodium sulfapyridine was repeated at the end of six hours and again at the end of another six hours. Four hours later (16 hours after operation) 1 gm. was given by mouth, with 20 gm. of nicotinic acid, and this medication was repeated every four hours, thereafter until 22 gm. had been given, on the sixth day after operation.

Daily blood studies were made from March 1, through March 5. The first revealed 4,980,000 red cells and 21,250 white cells per cu. mm., with 85 per cent polymorphonuclear cells; the second 4,990,000 red cells and 11,050 white cells per cu. mm., with 75 per cent polymorphonuclear cells; and the third 4,780,000 red cells and 6,650 white cells per cu. mm., with 70 per cent polymorphonuclear cells. At this time, March 3, a transfusion of 250 c. c. of citrated blood was given. March 4, the red blood cell count was 5,050,000 and the white cell count 7,800 per cu. mm., with 90 per cent polymorphonuclear cells. Another transfusion of 250 c. c. citrated blood was given March 5, when the red cell count was 4,750,000 and the white cell count 9,200 per cu. mm., with 70 per cent polymorphonuclear cells. All blood studies thereafter were within normal range.

The spinal puncture performed March 2 revealed fluid under pressure (400 mm. water). The cell count was 2,060 (95 per cent neutrophiles), the globulin 2 plus, and the colloidal gold 0011100000. Pneumococci type XIX were again present on culture. The following day, the fluid was under normal pressure, the cell count was 600, and there was only a trace of globulin. Pneumococci (type XIX) were again present on culture. March 6, no organisms were present and all other examinations of the spinal fluid were within normal range.

After the first 24 hours postoperative, the child's recovery was gratifyingly smooth in every respect. Roentgenologic examination of the chest March 18 showed no change, one way or the other, in the tuberculous lesion. She is still on a regimen of complete rest, but is entirely recovered from her acute illness. The cast was removed from the right knee after the mastoid operation, to add to her comfort, and the joint condition is apparently progressing favorably at the present time.

COMMENT

A partial survey of the literature since Hewell and Mitchell's publication has revealed fourteen additional recoveries following sulfapyridine or sulfanilamide therapy in pneumococcic meningitis.[2-11]

An interesting feature in the case reported herewith is that the blood culture taken at operation was positive for type XIX pneumococci. Hewell and Mitchell call attention to the fact that, although the data on this point are incomplete, recovery ensued in only one of the eight patients with positive blood cultures following sulfanilamide therapy. Evidently, as these authors point out, blood stream infection is an important factor in the mortality rate in this disease.

Unquestionably the tuberculous infection in this case added to the child's risk and might have been expected to be aggravated, itself, by the superimposed disease. This does not seem to have happened, nor does the sulfapyridine therapy seem to have exerted any effect, one way or the other, upon the tuberculous lesion.

Feldman and Hinshaw[12] found that sulfapyridine exerted an inhibitory effect on experimental tuberculosis in guinea pigs. Follis[13] demonstrated that sulfanilamide and acetylsulfanilamide, even in high concentrations, were practically without effect on the tubercle bacilli *in vitro*, although sulfapyridine in concentrations of 50 mg. or higher had some inhibitory effect. He considered that the differences between his results and those of Ballon and Guernon,[14] who found sulfanilamide effective *in vitro*, were to be explained by differences in the media used. Nayer and Steinbach[15] administered sulfanilamide to eight patients with

extensive pulmonary tuberculosis, for periods varying from 10 to 71 days, without any effect whatsoever. This is in line with my own observations in the case reported, and it seems reasonable to say, in view of the confusion of experimental facts, that at the present time sulfapyridine exerts no beneficial effect in pulmonary tuberculosis.

SUMMARY

1. A case is reported of pneumococcic meningitis complicated by pulmonary tuberculosis and tuberculosis of the knee joint.

2. Recovery from the meningitis promptly ensued following sulfapyridine, type specific rabbit serum, and surgical therapy.

3. The sulfapyridine therapy exerted no effect, one way or the other, on the tuberculous disease.

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ACUTE APPENDICITIS IN THE FEMALE*

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Because of the continued high mortality from the disease, the subject of acute appendicitis must at all times be considered a very important one. Furthermore, as the surgeon's responsibility is increased and the problem which confronts him is multiplied when he is called upon to make a differential diagnosis in an acute lower abdomen in the female, it is well to review, from time to time, those factors which most frequently complicate the diagnosis of acute appendicitis in the female.

The disease develops more frequently in the female than in the male. The morbidity is not influenced by sex but abdominal pain of varying types and degrees is more or less a frequent complaint in women at some time or other. The pathology of appendicitis in the female is the same as in the male, excepting in such instances where the appendix becomes involved secondarily to an adnexal inflammation. Here the picture is usually one of a peri-appendicitis, in itself not a grace situation; as a matter of fact the condition is usually first discovered during the course of routine pelvic surgery.

Disturbances in the urinary tract and in the pelvic organs frequently give rise to symptoms which simulate acute appendicitis and it is only by a comprehensive history, careful abdominal and pelvic examination and corroborative laboratory evidence that a differential diagnosis can be made.

The history must not only include the menstrual history but should go further and include a complete gynecologic history. This is of the utmost importance as the history alone frequently points to the diagnosis, a fact too often overlooked or passed over too lightly.

The causes of acute lower abdominal pain in the female are quite numerous but I shall

*Read before the sixty-first annual meeting of the Louisiana State Medical Society, New Orleans, April 23, 1940.

only review those which occur most frequently, at least in my own experience.

ACUTE CYSTITIS

The onset of this disease is frequently sudden and accompanied by severe pain in the lower abdomen. The pain is described as being of the pressure type or bearing down in character and it is localized over the region of the bladder, though at times it appears to center in an area corresponding to the right side of the bladder.

The classical symptoms of frequency or burning on urination are often absent in the early stages of this disease as are the positive findings of pus in the urine. These only appear after the organ involved has had time to react to the infection; hence the examination of two or three catheterized specimens is a proper procedure. It is well to remember that nausea and backache are frequent associated symptoms.

Intravaginal pressure upon the urethra will often elicit pain, frequently a helpful point in diagnosis. The blood picture is typical, a slight total leukocyte increase and a more marked neutrophilic percentage. As many cases of cystitis develop following an acute intestinal disturbance, the possibility of a coexisting pelvic appendicitis must not be discounted. I recall very vividly such a case, having been called to see a young woman complaining of nausea, vomiting and moderate generalized abdominal pain with the point of major tenderness in the region of the bladder. Within 24 hours, the urinary findings were positive and with symptomatic and urinary therapy, her general condition improved to a point where the morning of the third day, her temperature was normal and she was symptom free. That night she developed a high temperature with acute pain localized this time in the lower right quadrant. This second abdominal crisis, diagnosed as an acute appendicitis, was confirmed at the time of operation. An acute suppurative pelvic appendix was found adherent to the right margin of the bladder surface.

ACUTE SALPINGITIS

The pain which characterizes the onset of this disease is usually of an acute nature. There is generalized discomfort over the entire lower abdomen with high temperature and nausea and vomiting. Localization of the pain is usually not difficult as it invariably is found to center immediately above Poupart's ligament in the region of the adnexa.

Whether or not a palpable mass is felt, vaginal examination always reveals a marked tenderness and immobility of the uterus due to inflammatory fixation and any attempt at raising the uterus invariably causes severe pain in the adnexal region. The temperature of the vagina is increased and the leukocytosis very pronounced.

Reference has already been made to the possible coexistence of acute salpingitis and appendicitis. If exploratory measures are taken in such cases, no harm can result from the procedure, providing the surgeon limits himself to the removal of the appendix and leaves the acute pelvic condition alone.

ACUTE INTESTINAL TOXEMIA

The predisposition of the female to constipation, particularly just prior to the onset of the menstrual period is well known. A situation frequently develops at this time, which results from active putrefactive changes in the large intestines, often of sufficient degree as to produce symptoms which simulate acute appendicitis; as a matter of fact it may be the forerunner of this disease in many instances.

The usual picture is a familiar one, namely, sudden onset with slight elevation of temperature, nausea or vomiting or both and generalized abdominal pain. The tendency is to frequent stools, usually highly colored and of a very offensive odor. There is little if any change in the blood picture. If the diagnosis is correct, the patient's condition shows marked improvement within a few hours. Nature has helped in a positive way by producing vomiting and diarrhea, and gastrointestinal rest, through the withholding of everything by mouth, serves to promote a rapid recovery.

OVARIAN DISTURBANCES

Among those to be considered in the making of a differential diagnosis are: Rupture of the graafian follicle, rupture of a corpus

hemorrhagicum and what can be designated as an ovarian crisis, this the result of excessive anterior pituitary like hormone therapy.

It is not uncommon for women to complain of acute abdominal pain at the time of graafian follicle rupture. This is the well known "mittelschmerz", which is frequently observed midway between the menstrual periods. Nausea is a frequent accompaniment and in some instances the pain persists for several hours. A slight bloody discharge occasionally appears. The patient also complains of pain and tenderness. The pain is localized in the ovarian region and intensified by palpation. There are no changes in the blood picture, and usually within eight to ten hours the patient is normal again.

Rupture of a corpus hemorrhagicum is not a frequent occurrence but must be included in any consideration of the status of an ovary. This condition occurs with greater frequency in young women with a tendency towards cystic changes in the ovaries. The history is important, as menstruation is seldom if ever normally established. Marked irregularity of interval, at times of several months, is complained of. Failure of the cyclic maturation of the follicle results in hemorrhage and degeneration with eventual rupture when this occurs, the localized pain in the adnexal region may be severe and is accompanied by nausea and a degree of shock. There is usually a slight leukocytosis and temperature, and low backache is a usual symptom.

What I have referred to as an "acute ovarian crisis" is the acute pain in the ovary which has been observed following the excessive administration of anterior pituitary like hormone. The rate of stimulation of this organ is out of proportion to the ability of the capsule to enlarge and, as a result of the intra-ovarian pressure, acute pain may develop. The history, the localization of the pain in the ovary and the absence of temperature are all differential points.

RUPTURED TUBAL PREGNANCY

The symptoms and signs of this clinical entity are well known but may be overlooked. Again the history is of the greatest importance, as the patient may or may not have missed a menstrual period. There may have been intermittent spotting before the rupture developed. The onset is sudden, usually following effort of some kind, with acute abdominal pain which soon becomes generalized, nausea and a variable amount of shock. A bloody vaginal discharge frequently appears; rectal tenesmus may be complained of. The temperature is elevated as is the total leukocyte count.

Pelvic examinations reveal an enlarged pregnant uterus with evidence of an adnexal mass and a bogginess in the cul-de-sac. A feeling of crepitation is elicited in some cases. The progressive and rapid aggravation of all symptoms and signs suggest an acute abdominal emergency of this type.

ACUTE MESENTERIC LYMPHADENITIS

This differential diagnosis is very difficult to make as the clinical picture simulates acute appendicitis more than any other condition. Except that the pain tends to localize itself more about the umbilicus, there is practically nothing else to differentiate it. The pain may be just as acute as in appendicitis and all of the classical symptoms and signs may be present. The existence of this condition can only be determined by careful and ample exploration. In all probability, acute mesenteric lymphadenitis is the explanation for the apparently harmless looking appendix which is frequently removed.

SURGICAL PROCEDURE

In regard to the surgical approach, I have always been of the opinion that this is important. My preference has been to use the right rectus incision or the low midline incision and I have never had any reason to regret it. Either of these incisions permit of the satisfactory removal of the appendix, besides they lend themselves admirably to the purpose of exploring the pelvis and performing such additional surgery as may be required. The only possible objections to the use of either of these incisions, namely, the danger of postoperative hernia and the risk

of an ugly abdominal scar can be eliminated by any competent surgeon, as present day management of wounds insures the securing of good anatomic as well as cosmetic results.

Nothing is more disconcerting to the surgeon than to have a patient return several months later following an appendectomy with the same complaint of pain in the right side. This frequently means that the diagnosis has been missed, and the observation has been made that this has occurred in the majority of cases in patients showing a McBurney incision. Such patients usually secure a new medical advisor; therefore, good judgment and experience suggest that the type of incision employed should be dictated by the surgeon and not by the whim of the patient.

The surgeon, while weighing all the facts, should keep constantly before him the knowledge that acute appendicitis is strictly a surgical problem and is one which calls for early and immediate operation once the diagnosis has been established; where a reasonable doubt exists, he is fully justified in dong an exploratory operation.

As a differential diagnosis is not always easy to make, it appears that these borderline cases would in many instances be benefited by consultation before the decision to operate is reached.

SUMMARY

1. In the female, appendicitis occurs with slightly greater frequency than in the male. The mortality is not influenced by sex.

2. The diagnosis is more frequently difficult to make.

3. The more common causes which require differentiation are discussed.

4. The low midline incision is suggested as more suitable.

5. More consultations in borderline cases are recommended.

DISCUSSION

Dr. John F. Dicks (New Orleans): A discussion of the differential diagnosis of appendicitis must depend upon the anatomic structure of the male and the female. We might divide this discussion into inflammatory and non-inflammatory conditions. Under inflammatory conditions, we may classify acute and chronic salpingitis, ovarian abscess, and pelvic cellulitis. Under the non-inflammatory there are ovarian cysts, fibroids, extra-uterine pregnancy, twisted ovarian pedicles, and pelvic tuberculosis.

Under symptomatology there is very little difference between the male and the female. Appendicitis is often ushered in with pain in the upper abdomen, later localized in the right iliac fossa. In gynecologic conditions the onset is often not as acute, and the pain is localized in either lower iliac fossa. Menstrual disturbances are something we should pay a great deal of attention to. A careful menstrual history should be obtained because it often gives a clue as to the differentiation from appendicitis. Vaginal smears should be taken.

Repeated vaginal examinations are of importance. Sometimes when we make one vaginal examination and at a later date make another we get an entirely different idea than at the first examination. Examinations under anesthesia are also of great importance in differentiating a gynecologic condition from appendicitis. I had a case recently which illustrated that fact very forcibly. The patient gave a history of being pregnant. She was examined in the office, and I found what I thought was a mass on the right side and, I thought she possibly had an extra-uterine pregnancy. The patient was sent to the hospital and under a general anesthetic she was examined again. I then had a different impression from the one I had gained in the office. This is mentioned to show that repeated vaginal examinations, and examinations under anesthesia are often necessary to make an accurate diagnosis.

As to the incision, if you are in doubt about the diagnosis, do as Dr. LeDoux said and make a midline instead of a right rectus or McBurney. It is much simpler to remove a bad appendix through a midline incision than it is to do a hysterectomy or handle a bad pelvic infection through a right rectus or a McBurney.

Dr. Lucien A. LeDoux (In conclusion): I do not have anything else to add. I feel that the points I wanted to make have been presented. No attempt was made to review all of the possible conditions that might simulate or make the matter of diagnosis of appendicitis in the female more difficult. I simply reviewed the problems which I have met and which I am sure we all have to meet at some time or another.

EARLY DIAGNOSIS AND TREATMENT OF AMEBIC ABSCESS OF THE LIVER*

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The fact that amebic abscess of the liver still goes unrecognized in certain observed cases, the fact that the victims of this disease may suffer long periods of disability as the result of delayed diagnosis, we wish to recount some of the cases that have come to our attention. In this wise, we wish to point out some of the protean manifestations of the amebic hepatic abscess and to call attention to the necessity for an early suspicion of this disease in individuals who have many weeks, and even months, of chronic abdominal complaints, particularly upper abdominal pain with a low-grade intermittent fever and leukocytosis. An early diagnosis will be rewarded by rapid return to good health by simple medical measures. Too often, the clinician has depended upon a previous history of a concurrent amebic colitis to make him suspicious of an amebic abscess of the liver. While some abscesses have occurred during the course of an amebic dysentery, many amebic abscesses of the liver occur, not alone, but without the history or clinical findings of an amebic colitis, as well as in a total absence of amebic hemolytica in the stool.

In a review of a series of cases of amebic abscesses of the liver from the records of the Touro Infirmary from 1933 to 1940, the following is interesting to note:

Number of abscesses of the liver	18
Number of amebic abscesses of the liver	8
Number of cases of amebic abscesses of liver (operated)	5
Number of cases of amebic abscesses of liver (not operated)	3
Number treated with emetine (operated or not operated)	6
Number treated with emetine (operated)	2
Number with negative stool	5
Number with positive stool	1
Material from liver abscess—positive	1
Positive at operation and autopsy	1

*Read before the sixty-first annual meeting of the Louisiana State Medical Society, New Orleans, April 24, 1940.

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AMEBIC ABSCESS OF LIVER DEVELOPING SIMULTANEOUSLY WITH AMEBIC DYSENTERY

CASE NO. 1

This patient, a man of 51 years of age, gave a history of having had diarrhea, 10 to 20 stools daily with mucus and blood, abdominal cramps, tenesmus, fever and sweats, soreness in right upper quadrant of three weeks' duration. Physical examination revealed an elevation of the right diaphragm, abdominal tenderness most marked in lower, left quadrant and right upper quadrant. There was a mass 7 x 7 cm., semi-lunar in shape, below the left costal margin. X-ray examination showed marked elevation of the right diaphragm, fixation, and basal pneumonitis. The total white blood count was 32,000 with 90 per cent polys; stool, amebae plus; agglutinations negative. The emetine treatment was instituted with the result that x-ray check-up showed the disappearance of pneumonitis, but the diaphragm was still elevated. Fluoroscopic examination showed an L-shaped stomach. The stool examination was negative. On his discharge from the hospital, the mass in the left hypochondriac region was gradually diminishing in size.

COMMENT

This case illustrates the ever present possibility of having an amebic hepatitis or amebic abscess of the liver, complicating amebic dysentery. The value of detecting liver complications is appreciated when one considers the difference in line of treatment between uncomplicated amebic dysentery and amebic dysentery associated with abscess formation outside of the intestinal tract. While it is well recognized that amebic dysentery is controlled and cured wtih oral preparations only, such as oxyquinol as used today, these oral preparations will not suffice to relieve the pathology in the liver which is definitely aided and often entirely relieved by the employment of emetine. However, one should use very little, if any, emetine which is a cardiac and neuro-toxic drug, unless there is an abscess.

AMEBIC ABSCESS OF LIVER RECURRING IMMEDIATELY AFTER TREATMENT FOR AMEBIC DYSENTERY

CASE NO. 2

This patient was a man 42 years old, who complained of having frequent bloody stools and severe abdominal cramps. This condition started about

two months previously. He was given ipecac. He was found to be very much undernourished. The physical examination revealed an asthmatic bronchitis which the patient believed was of twenty years' duration.

Proctoscopic examination presented a few small ulcers in the sigmoid. The stools contained numerous flagellates of the chilomastix and trichomonas species and *Endameba histolytica.*

The patient was placed at absolute rest on a soft diet. He was then given a course of stovarsol (daily) until he had taken 25 tablets. Twenty days later he reported slight "weakness in the legs." The bowels had become constipated. The stools were found to be free of any parasites or cysts. Stovarsol was then discontinued. Two weeks later, while out at sea, dysenteric symptoms came on rather acutely, followed by pain in right upper abdomen and slight rise in temperature. A diagnosis of liver abscess was made. The total leukocyte count was 22,000 with 89 per cent neutrophils. He was then put on emetine for 12 days; also given bismuth subnitrate for the same period of time. Upon immediate return to New Orleans, the physical examination showed an enlarged liver, palpable 2½ inches below costal line, with a tender mass in the lower border of the right lobe. He was readmitted to the Touro Infirmary, with temperature 99° F., total white blood count 10,000 neutrophils 76 per cent.

Treatment was then directed towards possible surgical interference, in the way of hypodermic injections of emetine hydrochlorid, supplemented with quinine sulphate and strychnine sulphate. There was a gradual, but definite reduction in the size of the abscess.

AMEBIC ABSCESS OF LIVER WITHOUT AMEBIC DYSENTERY AND WITHOUT AMEBA BEING FOUND IN THE STOOL

CASE NO. 3

This patient was admitted to the Touro Infirmary with a complaint of severe pain in left upper quadrant, left shoulder and left chest, worse on inspiration (fever 99 3/5°, and leukocytosis 12,500 with 81 per cent polys). She had been suffering with the same type of pain for about three months. There was also a history of mucus in stools. She was treated for mucous colitis with no qualitative or quantitative dyspepsia. There was no nausea or vomiting. Physical examination was essentially negative, except for tenderness over the eleventh and twelfth ribs, anterior and posterior, left; generalized abdominal rigidity, marked tenderness in epigastrium and left upper quadrant. Chest; diminished percussion, left base.

Patient continued to run septic temperature of 102° F. All laboratory tests, including blood culture, agglutinations, urine culture, and stool examinations, were negative. There was leukocytosis of 12-27,000 with 81-90 per cent polys.

Emetine treatment was given this patient and a fluoroscopic examination showed some deformity of the duodenal cap. There was slight elevation of the left diaphragm with some limitation of motion particularly anteriorly. The costo-phrenic angle is now clear and basal pneumonitis entirely cleared.

COMMENT

Amebic abscess of liver may occur concurrently with other abdominal pathology. In this instance, a definite irregularity of the duodenal cap persisted in each examination. However, the abdominal mass was not a peri-duodenal infiltration due to a chronic perforated duodenal ulcer, but rather to a hepatic involvement. The abdominal mass as well as fever and leukocytosis disappeared completely following the use of emetine. This case illustrates another common finding, namely, secondary and inflammatory involvement of the lungs, shown on the radiograph as a pneumonitis.

AMEBIC ABSCESS OF LIVER WITHOUT HISTORY OF DYSENTERY AND WITH NEGATIVE STOOL EVIDENCE

CASE NO. 4

This patient had a cholecystectomy performed. The liver was found enlarged downward, gallbladder atrophic. He made an uneventful recovery in the next 19 days. He then began to run a low-grade fever, with loss of weight and developed an anemia. There was pain in the right lower chest. The stool was negative, but leukocytosis was noted. Physical examination revealed the following findings: anemic appearance, elevation of diaphragm on the right side posteriorly, and the liver palpable three fingers below right costal border.

Treatment: Blood transfusion 500 c. c.; exploratory aspiration in the ninth interspace, posterior axillary line, was productive of brownish fluid. A day later, a resection of the ninth rib (portion) was performed. The diaphragm was sutured to the liver. Patient expired and the final diagnosis was recorded as: Amebic abscess of liver; general peritonitis; acute dilatation of the heart.

COMMENT

The above case demonstrates the fact that toxic symptoms, fever, and leukocytosis may exist for a long period of time and gallbladder infection be suspected, when the true pathology is a slowly developing abscess of the liver caused by amebae. It is found that cholecystectomy in such cases is not a rare procedure and the error of diagnosis can be justified by the diffuse inflam-

mation of the biliary tract, including the gallbladder, in individuals who have an amebic hepatitis or abscess. When such procedures have been performed and the above described symptoms persist, it is certainly advisable to treat the patient with anti-amebic therapy, in spite of the absence of characteristics of liver findings. As demonstrated in this particular case, the enlargement of the liver and the elevation of the dome of the diaphragm could be found to be demonstrated only in the final stage of the disease, when secondary infection had already taken place and it was well known that it is this secondary infection which has shown the fatal issue which complicates the original abscess caused by amebae.

The onset of an amebic abscess of the liver does not occur spontaneously, but develops insidiously, and then there is a gradual rise in temperature with leukocytosis and increasing toxemia. Certainly, in the beginning, an amebic abscess of the liver is not associated with the typical clinical and x-ray signs, especially the elevation of the dome of the diaphragm as found in the mature well developed abscess.

TREATMENT

With the early diagnosis having been established, that is, diagnosis before massive pathology and secondary infection, which is much more serious, the treatment should be conservative and directed towards medical measures outlined in the above case description. It behooves one to administer emetine, but to administer these neuro-toxins very cautiously. In certain susceptible individuals, cardiac irregularities, and even failures, have been observed with small doses of emetine. Under these conditions of administration, it has been found that 1 grain of emetine intramuscularly, per diem, will suffice to bring about a gradual subsidence of the symptoms. Then, commensurate with the subsidence of the symptoms, namely, the fever, toxemia and leukocytosis, diminishing amounts of emetine should be administered.

SUMMARY AND CONCLUSION

The above series of cases of amebic abscess of the liver, which includes a certain hospital group seen over a period of seven years as well as a small series of private patients, serves to demonstrate certain salient points in connection with the disease in question. Once recognized, the chances for recovery in amebic abscesses of the liver are very good, regardless of the type of treatment. There was one death out of the hospital group and one death out of the private series, the latter not having been recognized until secondary infection had produced a toxic degeneration of the cardiac muscle. Under some conditions, such as the massive and medically irreparable degeneration of the liver due to invasion by the amebae, usually late in the course of the disease, it is obviously necessary to employ surgical interference. If secondary infection has apparently invaded the amebic abscess, quite often manifested by heart and kidney changes, it becomes necessary to evacuate the abscess.

If the diagnosis of acute cholecystitis should be made from upper abdominal symptoms of a severe nature and the removal of a diseased gallbladder does not relieve the patient, then one should be strongly suspicious of a coexisting amebic abscess of the liver.

DISCUSSION

Dr. Oscar W. Bethea (New Orleans): I think it is particularly fitting that we should have a discussion of the medical aspects of amebic abscess of the liver, and particularly by so competent an authority as the one who has just spoken to you. My long years of intimate association with him have given me the greatest respect for his opinion. I believe that we cannot too strongly endorse his emphasis with regard to early diagnosis in order that medical treatment may be applied, and yet, in looking back over the diagnoses that I have fumbled in past years, amebic abscess of the liver bobs up once or twice. Diagnosis is sometimes very difficult.

I wish to lend my endorsement particularly to his suggestion that emetine is the only parasiticide that will have any material influence on liver infection by the endameba. Chiniofon, or anayodin as it was originally called, is an iodine preparation, just as stovarsol and carbasone are arsenic preparations, and I do not believe that any of these are absorbed in sufficient amount to destroy the amebae that are reached only by the blood stream. I believe that emetine by hypodermic injection has a chance of doing that. In intestinal amebiasis,

we use both types of treatment, that is, the emetine to reach those that are in the intestinal wall and a parasiticide by mouth for those in the lumen of the alimentary tract.

I do not share entirely Dr. Silverman's dread of emetine though so great an authority as Colonel Craig agreed with his view. I have seen only two cases of emetine poisoning. Both patients were taking large doses of ipecac by mouth as well as emetine by hypodermic. Both patients recovered completely.

Reid's work on the Pacific Coast, which was the greatest survey of this subject ever made, led to two conclusions: (1) That in all cases of emetine poisoning the dosage had grossly exceeded any reasonable amount, or (2) danger signals had been totally disregarded.

Dr. Daniel N. Silverman (In conclusion): There is an old saying that the burned child dreads the fire, and my dread of emetine comes from cases of emetine poisoning.

THE MANAGEMENT OF CHRONIC SUPPURATIVE OTITIS MEDIA*

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Chronic suppurative otitis media is manifested by a continuous or intermittent discharge from the middle ear and results primarily from inadequate medical and surgical treatment of acute middle ear suppuration. The pus is usually foul, but may be odorless. There is deafness of varying degrees, depending upon the location and severity of the disease process. Pain is not a common symptom and its presence at once suggests insufficient drainage or intracranial complications. There may be a continuous dull headache. Dizziness usually indicates internal ear involvement.

CLASSIFICATION OF OTITIS MEDIA

According to Lillie, chronic suppurative otitis media may be classified into four clinical types, as follows:

Type 1. In this type the discharge from the ear is mucoid in character and without characteristic odor of decaying bone. The perforation may be small or large, and may be situated in any portion of the tympanic membrane, either central or marginal. There is no suggestive evidence of underlying disease of the bone. The history is one of periods of dryness, sometimes of long duration, with a recurrence of the discharge in any acute infections of the upper respiratory tract. The discharge in these cases seems to come from the eustachian tube alone and treatment toward this end will usually terminate in success. X-ray of the mastoid cells usually shows some sclerosis.

Type 2. This is about the same as Type 1, but there are added evidences of disease of the bone, such as necrosis of the ossicles, and polyps. The perforations are usually large and x-ray of the mastoid cells usually shows some sclerosis.

Type 3. The discharge is purulent in character and there is considerable evidence of bone necrosis. There is also evidence of disease in the attic and cholesteatoma may be present. The membrane tensa is usually destroyed. The hearing may vary from approximately normal to various degrees of deafness which is characterized by fixation of the stapes. The x-ray of the mastoid cells usually shows some sclerosis.

Type 4. In this type the discharge varies in quantity, but is always foul and has the characteristic odor of cholesteatoma. The drum may be intact and the discharge may come through a fistula in the wall of the superior canal without any involvement of the ear drum.

Varying degrees of nerve deafness may be present, a positive fistula test may be discovered and a caloric test may reveal varying degrees of malfunction of the canal. The x-ray of the mastoid cells usually shows definite evidence of the presence of cholesteatoma. When these conditions are present attempts at medical cure are usually dangerous to the patient.

TREATMENT

The treatment of chronic suppurative otitis media may be divided into medical and surgical. Types 1 and 2 are especially applicable to treatment. In these cases abnormal conditions of the nose and nasopharynx may have a great bearing on the condition and attention should be directed

*Read before the sixty-first annual meeting of the Louisiana State Medical Society, New Orleans, April 24, 1940.

towards correcting them, especially marked septal deflection and adenoidal vegetation. Some of the measures that have been used are the following: Installation of urea into the middle ear, x-ray therapy, alcohol and boric acid drops, alcohol and iodine, hydrogen peroxide, chromic acid, enzymol, cresatin, bacteriophage and vaccine, zinc ionization, silver picrate solution, and boric acid and iodine powder.

From my experience I think the best medical treatment is the installation of boric acid and iodine powder into the middle ear along with the proper medication or treatment of the nasopharynx. I believe that all types of watery solutions should be avoided as they leave the cavity moist and lead to maceration. In all cases it is important first to cleanse the auditory canal from all secretions. This can be done by means of cotton probes dipped into alcohol. This should be carried through the perforation and the middle ear should be cleansed as well as possible. If granulation or polyps are present these should be removed by means of a small curet or snare, using a great deal of precaution, especially if they seem to originate in the region of the promontory. In removing polyps from this region one should be careful to avoid traction and avulsion of the growth, which should be cut off as close to the origin as is consistent with safety. Further reduction may be secured by the use of a chemical cautery, which should be stopped if signs of irritation of the inner ear are produced. After the ear has been cleaned as well as possible (which may necessitate several visits of the patient), then the ear should be thoroughly dried and the iodine and boric acid powder placed into the ear, being careful that the powder comes in contact with all parts of the middle ear. At first the powder should be placed in the ear twice a week, using the one per cent, and this should be gradually increased until the two per cent powder is used.

The patient should also be warned to avoid the following: Autoinflation, nose blowing, ear douching, diving, swimming, water in ear when bathing or washing the hair.

The dietary habits of the patient should be investigated and the patient placed on a high caloric diet rich in vitamins A, B and C.

Wolbach has recently shown a keratinizing metaplasia of the mucosa of the nose, sinuses and respiratory tract in vitamin A deficient animals and infants. This would include the middle ear and mastoid cells. He has also shown changes in the bone marrow in the lack of vitamins, which would have an effect in a lowered resistance of the bone itself and in a general lowering of resistance of the patient.

According to the clinical classification, types 1 and 2, and possibly type 3, will usually respond to medical therapy. However, if there is marked evidence of bone necrosis with possible x-ray or clinical evidence of cholesteatoma, then medical therapy is usually futile and some type of surgery must be resorted to. The amount of surgery usually depends upon the pathologic process. If the drum has been largely destroyed, the ossicles and tympanic membrane should be removed. If there is no destruction of the tympanic membrane and if the disease is confined to the mastoid antrum and attic, then the structure of the middle ear is usually left intact.

CONCLUSIONS

1. The clinical classification of Lillie has been followed in this paper.
2. Almost all patients with this condition will respond to medical treatment.
3. The best medical treatment is boric acid and iodine powder.
4. If there is marked evidence of bone necrosis and cholesteatoma, then surgical intervention should be followed.

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DISCUSSION

Dr. Monte Meyer (New Orleans): There is only one thing I want to add to this paper and that is in reference to a problem which we face, all of us, at times. Some one brings a child to you, seven or eight years old, with a running ear for the last four or five years. Everything has been done, but the ear is still draining, and the hearing remains good. Are you justified in having the child undergo a radical operation? No matter what form of radical mastoid you do, there is a certain amount of destruction of hearing. My advice is just to watch. I do believe that since the introduction of high vitamin diet results are better than in the past.

Dr. Phillips (In conclusion): I think young children who have had a discharging ear for seven or eight years present the most perplexing problem. However, I believe that a high caloric diet plus boric acid and iodine powder will take care of a majority of these cases. In a few cases it may be necessary to anesthetize a child and explore the nasal pharynx in order to remove any abnormal vegetation that may be present. I do not believe that any patient with chronic otitis media should be operated on just to correct the discharge, unless there are signs of intracranial complications present, because it has been shown that from 33 to 50 per cent of these patients continue to have the discharge after operation.

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SYPHILIS CONTROL IN LOUISIANA*

FORD S. WILLIAMS, M. D.†
NEW ORLEANS

The problem of the so-called venereal diseases in this state has long been recognized. Both medical and social aspects of the most important one of these diseases, syphilis, have repeatedly been presented to interested medical, health, and social groups. Specialists in the City of New Orleans have continually bewailed the lack of facilities for diagnosis and treatment in other sections of the state for patients unable to pay. The lack of interest and knowledge among physicians in smaller towns and rural areas has been evident to those of the profession particularly interested in the problem.

Thousands of patients diagnosed as having syphilis in the charity hospitals of the state have been returned to their homes with recommendations for treatment or for further treatment when no local facilities for such treatment were available. Many of these same patients have returned to the attention of the physician or the hospital only after the pain of some late complication had prompted them to seek relief. Entirely too many such patients with cardiovascular syphilis and central nervous system syphilis, and other late complications, now fill the wards of our charity hospitals or mental institutions. They, and too often their families as well, present real medical, social and economic problems. And all the while health officers and physicians have seen crops of newly infected individuals appear—boys and girls, young men and young women, mothers or potential mothers with early acquired syphilis, new cases of syphilis in the newborn—many of which were the result of conception in women who, although previously known to have syphilis, received little or no treatment during pregnancy to prevent the birth of the syphilitic child. A majority of these new cases, under the old order, were destined to follow the same course as that described above.

All of this conclusively demonstrated to the thinking individual a need for an organized state-wide syphilis control program. I am glad to report that such a program is now in operation, and although only a modest beginning has been made, we have every hope that much can be accomplished.

NATIONAL PROGRAM

In 1936, Surgeon General Thomas Parran launched a nation-wide educational project in support of a proposed national venereal disease control program. I am sure that you are familiar with the ever-expanding public support given the Surgeon General in this venture. In the spring of 1938, the U. S. Congress passed the LaFollette-Bulwinkle Bill, or the so-called Venereal Disease Control Act of 1938. This Act, in addition to prescribing ways of control, also

*Read before the sixty-first annual meeting of the Louisiana State Medical Society, New Orleans, April 22, 1940.

†Director of The Division of Venereal Diseases, Louisiana State Board of Health.

provided the U. S. Public Health Service with means for a national control program.

Three millions of dollars were thus provided during the fiscal year ending July 1, 1939 and five millions of dollars were provided for the fiscal year ending July 1, 1940. Indications are that funds in increasing amounts will be appropriated by Congress each year for a period of thirteen years, as provided in the Act.

The U. S. Public Health Service distributes, to state health departments of the various states, the majority of this money to be used in the conduct of state programs, retaining a small per cent for research purposes and for the development of special training centers and special studies. Funds are distributed on the basis of three factors: (1) Population; (2) extent of the venereal disease problem; and (3) the economic need of the state. From this source, the State of Louisiana received during the past fiscal year approximately $55,000.00 and for the present fiscal year ending in July, approximately $97,000.00.

STATE PROGRAM

On July 1, 1938, the State Board of Health set up, under the Bureau of Parish Health Administration, a permanent full-time Division of Venereal Diseases to establish and maintain a state-wide venereal disease control program through the expenditure of these funds. In general, the apportionment of funds toward the establishment of local programs has been made on the following bases: (a) The relative prevalence and importance of the venereal diseases in relation to all communicable diseases in the area; (b) the financial need existing in each area as determined by recognized economic indices, and (c) the ability of the respective areas to utilize funds effectively.

For reasons obvious to those familiar with the subject, many more real measurable results can be expected in the control of syphilis than in the control of the other so called "venereal diseases." Therefore, it was decided in the beginning that major emphasis would be placed on this disease. In the formation of a state-wide program, we should know something about the extent of the problem, about the prevalence and incidence of syphilis in Louisiana. Several methods could be used to obtain this information, some of which are:

1. A study of case-reporting by private physicians.
2. A study of hospital and clinic reports.
3. The so-called "Wassermann survey."
4. A study of patients admitted to state institutions with late complications such as involvement of the heart and great vessels or involvement of the central nervous system.
5. Comparative studies of the amount of syphilis occurring in pregnancy.

I am sorry to say that, due to various factors, none of these methods have as yet been successfully applied. Case reports received to date from physicians, hospitals and clinics are meager, incomplete and lack conformity, and are, therefore, of little use.

In only one area are figures available from Wassermann surveying, and these will not bear close statistical analysis. In East Carroll Parish, better than 4,000 negroes were tested, representing approximately one-third of the total colored population. Twenty-seven per cent of this number was found to have one or more positive serologic tests.

From our own experiences thus far, and from the application of rates determined for near-by states, we believe that the following statements can be accepted: Twenty per cent to 35 per cent of the total colored population is infected; five to 10 per cent of the total white population is infected. The rate among the colored is higher in the delta cotton-producing areas along the river and in the South Louisiana sugar and rice-producing areas. The rate is approximately twice as high for both races in the urban areas as in the rural areas, and correspondingly higher in the large cities. Several factors, including geographic location, prostitution, and transportation, lead us to believe that syphilis is relatively more prevalent in the seaport cities of New Orleans and Lake Charles than in other of the larger cities of the state.

I believe that we can accept the principle that the ultimate control of syphilis will come through one or both of two measures, namely: (1) Prophylaxis and (2) the location of infectious persons and their continuous treatment to a state of permanent non-infectiousness.

PROPHYLAXIS

Some of you may have witnessed the effectivenes of prophylaxis under military control during the first World War. Unfortunately, this measure cannot be applied to the civilian population in the same manner. Although many authorities feel that prophylactic agents now available—mechanical, chemical, and otherwise—are not being used to the best advantage, it is generally conceded that there is a great need for a new, easily applied, effective and inexpensive prophylactic agent. Since prophylaxis is so intimately connected with the question of contraception and related moral issues, this method is not actively used in most organized syphilis control programs. On the other hand, the diagnosis and treatment of infectious persons so as to render them permanently non-infectious, is the underlying principle used in a modern program.

Since this be true, we must develop a medium through which this procedure can be applied to all population groups in the state, including both those patients who are able to pay for these services and those who are unable to pay. With this in mind, the Louisiana State Health Department presented certain policies and plans to the Committee on Venereal Disease Control of the State Medical Society. These policies were unanimously approved by the members of the committee present, and the matter was referred to the Executive Committee for further action.

Briefly, it is planned that the State Health Department offer to each licensed practicing physician in the state assistance in the management of cases of syphilis in the practice of the individual physician, the type of assistance offered to be as follows:

1. Free laboratory facilities for diagnosis and treatment guide among patients who are unable to pay for such services. Facilities are included for serologic tests of blood, darkfield examinations and examinations of cerebrospinal fluid.

2. Professional education in diagnosis, treatment and control.

3. Consultation service for patients unable to pay consultant fee.

4. Free drugs for the treatment of all patients with syphilis who are unable to pay full fees.

5. Free public clinics at key points in the state to which patients who are unable to pay private physicians for anti-syphilitic treatments may be referred.

It is understood that: (1) All cases of syphilis must be reported to the Health Department, as required by law; (2) basic information concerning the cases of syphilis under treatment by the private physician will be maintained.

In other words, it is our aim to offer as much assistance as possible to the private physician in the management of all cases of syphilis in his practice whether they be pay, part-pay or indigent patients. In addition, we propose to establish free public clinics to which the physician may refer those indigent patients whom he does not care to treat.

During the past two years, the State Health Department established two additional branch laboratories, one located at Franklin, in St. Mary Parish, and the other located at Jennings, in Jefferson Davis Parish. Additional technicians have been employed for other laboratories in the state. A plan has been developed which will go into effect in May, whereby laboratory services available from all laboratories will be improved and made uniform. Facilities for darkfield examination have been placed in a number of established clinics.

In November, 1938, a Special Training Center for the teaching of diagnosis, treatment and control of syphilis to health officers, physicians, nurses and medical social workers, was established at the Louisiana State University Medical Center through

a cooperative arrangement with the Medical School, the State Health Department and the U. S. Public Health Service. To date, 26 health officers and private physicians, ten nurses and one medical social worker from Louisiana have received intensive courses of training here. Refresher courses, to be conducted at key points in the state by physicians having special knowledge of syphilis and its control, have been planned. These courses, to be given cooperatively by the health department and the Committee on Education of the Louisiana State Medical Society, will be conducted in the same manner as those previously given throughout the state in the field of maternal and child hygiene. If our program is to be a success, well-trained, qualified, professional personnel must be made available.

Any physician may refer any patient for consultation to clinics operated by the Health Department provided the patient is unable to pay consultant fees. The patient will be returned to the referring physician together with a written report of the consultation.

Free drugs for the treatment of all patients with syphilis who are unable to pay full fees may be requested. The ability of the patient to pay will be left entirely to the discretion of the physician. Although free drugs have not been distributed to all physicians in the state who are treating syphilis, no recent requests have been rejected by the Health Department. It is understood that no drugs will be supplied physicians who do not properly submit morbidity reports and who do not supply requested information. In the near future, we propose to modify the system now in effect for the case reporting of venereal diseases. Also, it will be necessary to develop a system of records for the distribution of drugs. When these things are done, each physician in the state treating syphilis will receive proper information from the Health Department. I can assure you that physicians will not be requested to submit unnecessary information or to keep unnecessary records in connection with this program.

FREE CLINICS

Prior to 1936, there existed in this state, outside of the City of New Orleans, only two free public clinics for the treatment of syphilis. To date, 52 free public clinics are in operation in 26 of the 42 parishes in the state having full-time parish health units. These clinics are conducted under the supervision of the local health unit, as part of a local organized syphilis control program. Syphilis control is a recognized, legitimate public health activity which should be included in the program of any well-rounded community health service. It is therefore our aim to integrate syphilis control into the generalized public health program conducted by each of the 42 parish health units in the state. Obviously, efficient control programs can best be established in communities already receiving full-time health services. Four full-time clinicians and 42 part-time clinicians are employed. Although health officers still serve as the clinician in a few clinics in areas where qualified clinicians are not available or not interested, it is our purpose as soon as possible to employ clinicians for all clinics. The health officer can best spend his efforts with the public health side of the problem rather than with the clinical side.

The following statistics are available concerning patients with syphilis under treatment at these clinics during the semi-annual period July to December, 1939:

I.	New admissions:	
	Cases of acquired syphilis	2,527
	Cases of congenital syphilis	235
	Total	2,672
	Acquired cases having early syphilis (duration of infection less than two years)	1,048
	Acquired cases having late syphilis	1,479
	Cases of syphilis in pregnancy	
	Admitted prior to fifth month	59
	Admitted fifth month or after	82
	Total	141
II.	Average number of cases under active treatment at any one time	5,195
III.	Total number of clinic visits	91,266
IV.	Number of injections of anti-syphilitic drugs administered:	
	Arsenicals	40,339
	Heavy metals	45,331
	Total	85,670

Only those patients who are unable to pay for anti-syphilitic treatment are accepted. No patients are admitted who are not referred by officially recognized welfare agencies or by licensed practicing physicians.

In addition to the diagnosis and treatment of individual cases, there are four other procedures known to be of value in syphilis control. These are: education, case-finding, case-holding and the passage and enforcement of proper laws.

I have already mentioned the need for professional education and plans along this line. Education of the lay public is also important. Here, the social worker comes into the picture. In addition to solving the many social and economic problems presented by the syphilitic and his family, and in addition to assisting in the passage of proper laws, the social group can do much in the way of lay education. We health officers prefer to leave the social hygiene aspects of venereal disease control to the social hygienists.

The private physician can play an extremely important part in case-finding. In reality, the offices of private physicians compose the first line of defense against syphilis. The private practitioner has the first opportunity to make a diagnosis of early syphilis. Each physician, to hold successfully his part of the line, must possess, in the words of Dr. Stokes, "a high index of suspicion." And even this is not enough; he must take more bloods for routine serologic examination since approximately 65 per cent of all persons admitted to medical care present no signs or symptoms of the disease.

All hospitals and clinics, both private and public, should routinely blood test all admissions.

The health officer has available two useful methods for case-finding, the first being so-called "Wassermann surveys" and the second, "contact tracing." The dragnet surveys are most useful in population groups that are heavily infected, and the latter "sharp shooting" method is most useful where the infection rate is relatively low. Although the practitioner should lend his assistance and support, his position is not such that will permit him to go out into any population group and find cases by these methods. However, suspects found that are able to pay are referred by the Health Department to the private physician for diagnosis and/or for treatment. It is hoped that the physician will not only perform necessary clinical and laboratory examinations to prove or disprove a diagnosis of syphilis, but that he will also search for and treat conditions other than syphilis which may be affecting the health of the individual.

Although specific drugs are available, the adequate treatment of syphilis is a long, drawn out, painful, expensive and relatively unsatisfactory affair. Therefore, case-holding is an important procedure in syphilis control. The reasons why patients lapse treatment are many, most important of which are cost, lack of transportation, incompetent medical services, incompetent nursing services, unkindness or lack of sympathy, and reactions to drugs. A great deal can be accomplished by education of the patient and by removing possible or actual causes for lapsation of individual cases. We are particularly interested in keeping infectious persons under treatment until a state of permanent non-infectiousness has been reached. According to Public Health Service standards, this requires a minimum of 20 injections each of an arsenical and a heavy metal (usually bismuth). All public health clinics are graded not on the total number of patients admitted or on the total number of injections given, but on the average number of injections administered to early cases before lapsation occurs.

The public health nurse is usually the one responsible for the field duties connected with contact investigation. She is the one who must locate and cause to be examined, either by clinic or physician, familial and sexual contacts named by original cases. She is also responsible for the return of patients lapsing treatment. Therefore, much depends upon the efforts of the nurse.

The following statistics covering these activities in connection with our organized clinics are available for the semi-annual period July to December, 1939:

CONTACT INVESTIGATION

Number of contacts named		1,421
Number of contacts examined		1,134
Number of contacts found infected		
Prenatal (congenital)	35	
Acquired	304	
Total	339	339
Number infected, but not under treatment		281
Number induced to begin treatment		239

FOLLOW UP OF DELINQUENTS

Total number of lapses without permission	5,632
Total number of returns to treatment because of follow-up efforts	2,413

Time does not permit a detailed discussion of the last but not least important procedure useful in the control of syphilis, that is, the passage and enforcement of proper laws. Our present laws relating to all communicable diseases need revision. Special laws, such as prenatal and premarital, are of undoubted value when technically correct and properly executed. Certainly a premarital law should require the examination of both applicants for marriage and should require performance of laboratory tests for the diagnosis of hidden disease.

SUMMARY

I do not feel that I can close any discussion on syphilis control without mentioning the importance of case selection. The health officer must use discretion in the selection of syphilis control procedures in order that his purpose might be accomplished: that is, the ultimate control of syphilis. In like manner, the clinician must use a rigid method of case selection in the admission of patients for treatment. I personally feel that a great many patients with syphilis are now under treatment for whom treatment will accomplish little, either from the standpoint of the public health or from the standpoint of the welfare of the individual patient.

DISCUSSION

Dr. J. R. Heller, Jr. (New Orleans): Dr. Williams has given us a clear exposition of the venereal disease control program in Louisiana and I have only a few reflections concerning the program.

We have not been able to apply properly the so-called modern methods of venereal disease control. From the public health standpoint, syphilis control is somewhat different, in that treatment is the most powerful weapon in the armamentarium. As can be expected, we have progressed with the treatment, and that is as it should be. In Louisiana, as Dr. Williams pointed out, different methods of control have been utilized; that of treatment, of course, has been projected probably to the greatest extent.

I wish to recall to you that these Federal venereal disease funds appropriated by Congress, are allocated to the states on three bases: The population, the financial needs, and the extent of the venereal disease problem. It is easy to see that the states of the South would benefit most because usually the financial need is the greatest here, and the problem has been clearly defined as an obvious major public health problem.

I think much credit should be given the State Health Department for the advance in the number of venereal disease treatment clinics from two to 52. One is tempted to wonder why efforts to establish clinics have not been as successful in the urban areas as in the rural. Why are there not reasonably adequate programs in New Orleans, Baton Rouge, and Lake Charles? Probably, time will remedy this deficiency.

The role of the practitioner is of paramount importance in venereal disease control, particularly in regard to syphilis. About 66 per cent of all new early syphilis cases come first to the attention of the private practitioner. He is the one who has the greatest responsibility, in that he can direct these patients to the proper clinics or other medical treatment sources, if necessary, and of course, it is his opportunitv to do the most along educational lines. That is why it is so important for the private practitioner to understand completely and to cooperate to the utmost in the venereal disease control program of the State Medical Society and the State Health Department.

NEW ORLEANS
Medical and Surgical Journal

Established 1844

Published by the Louisiana State Medical Society under the jurisdiction of the following named Journal Committee:

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SUBSCRIPTION TERMS: $3.00 per year in advance, postage paid, for the United States; $3.50 per year for all foreign countries belonging to the Postal Union.

News material for publication should be received not later than the twentieth of the month preceding publication. Orders for reprints must be sent in duplicate when returning galley proof.

THE JOURNAL *does not hold itself responsible for statements made by any contributor.*

Manuscripts should be addressed to the Editor, 1430 Tulane Avenue, New Orleans, La.

*Died July 2, 1940.

JOHN ALEXANDER LANFORD
(1881-1940)

It is with sadness that we record the rather sudden death of Dr. John Lanford, a member of the Journal Committee for ten years. With the passing of this well-known pathologist, the Journal loses from its administrative ranks a man who worked faithfully and diligently to make the Journal a high standard state medical periodical. His good advice, his sane judgment, and his knowledge of men and affairs made him a splendid and loyal man for his position on the Journal Committee.

Lanford was born in 1881 in Gainesville, Alabama. He went to Auburn prior to graduating from the University of Alabama Medical School in 1905. He then migrated to New Orleans, where he became connected with the Department of Pathology of Tulane and in 1912 became pathologist of Touro Infirmary. Since 1914 he held the position of Assistant Professor of Pathology and Bacteriology in Tulane Medical School. He was consulting pathologist for several New Orleans hospitals. During the World War, Lanford had a variety of experiences in the two years he served in this country and in France. Following the War, he advanced in the Medical Reserve Corps to the rank of Colonel, obtained in 1932. He was active and a leader in the Reserve Officers organization in New Orleans.

President of the Orleans Parish Medical Society in 1932, and for many years before this Treasurer of the organization, Dr. Lanford was very active in the State Medical Society. As Chairman of the Cancer Committee since 1932, he put on a vigorous and active campaign to reduce the mortality of this dread disease. He was a member of many national societies as well as local organizations.

Lanford was a man of delightful personality; he was liked by every one with whom he came in contact. He was a vigorous and intelligent worker in whatever he undertook. Those who attended his clinico-pathologic conferences at Touro will always remember with pleasure their excellent presentation. His death will not only be a loss to the Journal and to the organizations in which he was actively working, but also to a host of friends and medical associates.

AVIATION MEDICINE

In this day of European conflict and urgent rapid American preparedness, aviation and its associated problems are of tre-

mendous importance and interest. As a result of the growth of aviation, the increasing use of the airplane commercially, and its demonstrated importance as an instrument of warfare, there was developed a special field of medical knowledge and investigation dealing with those individuals who fly.

Armstrong* briefly reviews the historical aspects of the subject and points out that this relatively new and rapidly growing field of medicine is not only of interest to specialists in this phase, but also to the general medical profession. It offers opportunities for physicians both in civil and military life.

As a result of World War I it was definitely shown that the careful selection of pilots on a physical basis was absolutely essential. Statistics showed that of every 100 pilots killed, two died as a result of enemy action, eight from defective equipment, and 90 from defects in the pilots themselves. As many as 50 per cent of the students in training developed neuroses before graduating as pilots. As a result of this experience a postgraduate school of training for flight surgeons was made a part of the Army medical education system.

There are over 31,000 licensed airplane pilots and 15,000 more in the training process in this country today, according to Armstrong. These must all be kept in physical and mental health. There are many special problems concerned with this task and the medical profession must acquaint itself with them.

The Army Medical Department is providing courses in aviation medicine for its medical officers. George Washington University School of Medicine presented a postgraduate course in aviation ophthalmology and aviation medicine this year, and two undergraduate schools have begun lectures on the subject to juniors and seniors. Armstrong predicts that other medical schools will undoubtedly follow this lead.

The rapid development of aviation medicine offers an opportunity and a challenge to the medical profession which it must meet.

*Armstrong, Harry G.: Developments in aviation medicine, Ann. Int. Med., 13: 2212, 1940.

MEDICAL PREPAREDNESS

The Committee on Medical Preparedness of the American Medical Association, established by the House of Delegates at the recent meeting, is circularizing the profession to secure their cooperation. A questionnaire is included for the purpose of properly cataloging information on the entire 117,000 or more members. This information is to be used only in connection with military purposes and is to facilitate prompt, immediate action in case of a military emergency to this nation.

Certainly every physician should be entirely willing to cooperate with the committee in this laudable endeavor. The medical profession responded and served nobly in the past, and there is no reason to doubt that they will respond again as adequately. All of us realize the necessity for preparedness, and this should be our contribution to the attempt to further this idea. Every member of the State Society is therefore urged to answer and return the questionnaire to the Committee on Medical Preparedness as early as possible.

HOSPITAL STAFF TRANSACTIONS AND CLINICAL MEETINGS

HUEY P. LONG HOSPITAL

Pineville

The following cases were presented at the weekly staff meetings and pathologic conferences held during the month of June:

1. This is the case of a 36 year old colored female who entered the hospital as a known syphilitic and had an ulcerative stomatitis. She presented the picture of extreme weakness and anemia, and was given a blood transfusion immediately after which a blood picture showed 9.2 grams, and 54 per cent hemoglobin, total red blood cells 3,870,000; white blood cells 12,000, 71 per cent polymorphonuclears, 20 per cent lymphocytes, 9 per cent monocytes; platelet count of 1,880,000 was also obtained

at this time. A sternal puncture was done and a smear obtained which revealed 10 per cent megalokaryocytes. Although only about 10 cases have been reported in the literature, a provisional diagnosis of megalokaryocytic leukemia was made. The patient remains in fair condition at the present time.

2. This is the case of a 35 year old white female who entered the hospital on June 22, 1940 at 8 a. m. On admission the patient was in profound shock and in a moribund condition. She had had a previous cesarean section in 1937. The patient had been having severe pain at the sight of the old cesarean section scar for 36 hours. Three hours prior to admission to the hospital the family physician had given the patient 1 c.c. of thytuitary. Immediately following the administration of the oxytocic the patient went into collapse at which time she was sent to the hospital. Emergency treatment for shock was instituted on admission but the patient died 50 minutes after admission to the hospital. It was evident that the patient had a ruptured uterus. A postmortem cesarean section was done and a dead baby was found free in the pelvic cavity. The uterus was ruptured at the site of the previous section and the abdominal cavity was filled with blood. The uterine rupture extended into the placental site with half of the placenta being free in the abdominal cavity.

3. This is the case of a 71 year old black male who entered the hospital complaining of locked bowels and vomiting of two weeks' duration. There were several small bowel movements until five days prior to admission since which time he had had no bowel movements but had continued vomiting with small pain around the umbilicus. The patient was operated for acute appendicitis in 1939 and had been considered in good health until onset of present illness. On admission the patient was extremely emaciated with a blood pressure of 190/140. All other physical findings were negative except for the abdomen which was moderately distended with some generalized tenderness, tympany above the umbilicus and a flat note below. A Wangensteen suction was started and a large amount of fecal-bearing material resembling the vomitus was obtained. The patient was given a rectal flush and a small amount of fecal material was expelled. Distention recurred each day during his stay in the hospital and each time was reduced by a Wangensteen suction and colon tube. The patient became progressively weaker and at no time was he in a condition to permit surgery. He expired on the seventh hospital day. Autopsy findings were intestinal obstruction which was produced by adhesions, apparently following the appendectomy, a section of gangrenous terminal ileum about 20 inches long and a generalized peritonitis.

4. This is the case of a 43 year old black female who entered the hospital May 30, 1940 about eight and one-half months' pregnant. Two days prior to admission the patient had painless vaginal bleeding, passing several small clots. A provisional diagnosis of possible placenta previa or possible premature separation was made. A sterile vaginal examination was done and a friable, bleeding, eroded cervix was found. Pathologic examination of biopsy revealed adenocarcimona of the cervix. A Porro section was done and and a normal, living, mature child was delivered. Patient is receiving deep x-ray therapy at intervals to the present time and is doing nicely.

Respectfully submitted,

A. K. Morris, M. D., Sec.

TRANSACTIONS OF ORLEANS PARISH MEDICAL SOCIETY

During the month of July, the Society held one regular scientific meeting, at which the following program was presented:

1. Biographical Sketch: Dr. Warren Stone.
   By invitation.....Mr. Joseph Schlosser.
2. Special Report: The Cause and Prevention of the Loss of Teeth.
   By.....Dr. C. C. Bass.
3. Symposium on the Effect of High Temperature on Body Functions:
   a. The Regulation of Body Temperature.
      By.....Dr. Henry Laurens.
   b. A Review on the Effects of Heat.
      By.....Dr. P. H. Jones, Jr.

The following physicians were elected to membership in the Society:

Active: Dr. Woodard D. Beacham; Intern: Drs. Mervin E. Fatter and Horace L. Wolf.

The Louisiana Association of Pathologists was formed Monday, June 24, an organization to promote closer cooperation among pathologists. At this meeting the following were elected to office: Drs. Edwin H. Lawson, president; Béla Halpert, vice-president; A. V. Friedrichs, secretary-treasurer; Maurice Couret, W. R. Mathews, and J. G. Pasternack members of the council.

The Secretary reports with regret the loss of Dr. John A. Lanford, one of the Society's active members.

NEWS ITEMS

Dr. Sydney Jacobs attended the recent meeting of the National Tuberculosis Association in Cleveland.

Drs. Erwin Wexberg and George F. Roeling recently attended the meeting of the American Psychiatric Association in Cincinnati.

Dr. Ambrose H. Storck attended a meeting of the American Neurological Association in Rye, June 6-8.

Dr. E. A. Socola attended the joint annual conference of the American Association of Medical Milk Commissions and the Certified Milk Producers' Association in New York, June 10-11.

Dr. E. L. Leckert was re-elected president of the Class of 1900 of the old Boys' High School at a reunion of this group held on June 13.

Dr. Donovan C. Bowne read a paper entitled "Primary Jejunal Pathology" at the American Medical Association convention in New York, June 10-14.

Drs. Gilbert C. Anderson, C. Grenes Cole, Eugene H. Countiss, J. A. Danna, Peter Graffagnino, Emmett L. Irwin, P. T. Talbot, and Edwin L. Zander attended the meeting of the Lafourche Valley Medical Society, June 19. Dr. Graffagnino presented a paper on "Office Endocrinology."

Drs. Max M. Green, Edgar Burns, and W. A. Reed attended the meeting of the American Urological Society in Buffalo, June 24-28.

Dr. T. B. Sellers addressed the Fifth District Medical Society in Monroe, June 25. The title of his talk was "Dysmenorrhea."

Dr. Isidore Cohn was guest speaker at the meeting of the Third District Medical Society in New Iberia, June 27. The subject of his talk was "Abdominal Surgical Problems."

Dr. W. J. Otis attended the meetings of the American Neurological Association and the National Catholic Hospital Association of America and Canada. Dr. Otis was also elected vice-president of the Federation of Catholic Physicians' Guilds of America.

Of the 69 students of the School of Medicine of Louisiana State University who received the Doctor of Medicine degree at the University commencement in Baton Rouge, June 2, 45 are from the State of Louisiana. Thirty-one also hold the degree of Bachelor of Science and 10 others the degree of Bachelor of Arts.

Physicians' attention is called to the advertisement of the National Physicians' Committee, which appeared in the June 22 and July 13 issues of the Saturday Evening Post.

TREASURER'S REPORT

Bank balance, May 31, 1940	$4,929.60
June credits	$ 171.17
Total credits	$5,100.77
June expenditures	$ 592.63
Actual book balance, June 30, 1940	$4,508.14

Edwin L. Zander, M. D.,
Secretary.

LOUISIANA STATE MEDICAL SOCIETY NEWS

CALENDAR

PARISH AND DISTRICT MEDICAL SOCIETY MEETINGS

Society	Date	Place
East Baton Rouge	Second Wednesday of every month	Baton Rouge
Morehouse	Second Tuesday of every month	Bastrop
Orleans	Second Monday of every month	New Orleans
Sabine	First Wednesday of every month	
Second District	Third Thursday of every month	

JOURNAL COMMITTEE RESOLUTION

The Journal Committee of the Louisiana State Medical Society met in sorrow today because of the death on July 2, 1940, of Dr. John A. Lanford.

Dr. Lanford was elected a member of this Committee in 1930 and has been a member continuously since then. In 1937 he was elected Secretary of the Committee and held this office at his death. He gave the same serious and faithful service to his work on the Committee that he gave to the many other positions of honor and trust conferred on him by his associates. He was a tower of strength to the Committee, especially in the matter of finance, and will long be missed from our counsels.

We extend our deepest sympathy to his relatives in their sorrow, offering only the inadequate consolation that we will cherish the memory of his too brief association with us.

PHYSICIANS NEEDED FOR ARMY SERVICE

The physician, like every other American, has become actively interested in our national security.

and stands ready to contribute his services as required for military preparedness.

The immediate problem in this connection is one that concerns the War Department, and primarily the young physician. The War Department must procure additional personnel from the medical profession to augment the medical services of the Regular Army as the various increases are made in the strength of the Regular Army, as authorized by Congress to meet the partial emergency. The young physician is especially concerned because it is usually advantageous, and is is often more convenient for him to serve with the Army.

Present plans of the War Department are designed to make service attractive and instructive for the young physician. If the physician holds a Medical Corps Reserve commission he can be ordered to active duty if he so requests. If he does not hold a commission, but is under 35 years of age and is a comparatively recent graduate of an accredited school, he may secure an appointment in the Medical Corps Reserve for the purpose of obtaining extended active duty for a period of one year or longer. Duty is given at general hospitals, station hospitals, and with tactical units, and embraces all fields of general and specialized medicine and surgery. Excellent postgraduate training is obtainable in connection with aviation medicine. After serving six months of active duty in the continental United States, a Reserve officer may request duty in Hawaii, Panama, or other United States territories and possessions. The initial period for duty is for one year and yearly extensions are obtainable thereafter until the international situation becomes more clarified and our domestic military program becomes stabilized.

Many young doctors who have served with the Army on extended active duty have taken the competitive examination for entrance into the Medical Corps of the Regular Army. Extended active duty affords an excellent opportunity for the physician to observe modern military medicine and the facilities that exist for a complete and comprehensive medical practice.

Further information may be obtained by writing to The Surgeon General, U. S. Army, Washington, D. C.

MEDICAL CORPS OF THE U. S. NAVY

The next examination for doctors of medicine desiring to enter the Medical Corps of the United States Navy will be held on August 19, 1940, at the following Naval Medical Department activities:

U. S. Naval Hospital, Chelsea, Mass.
U. S. Naval Hospital, Brooklyn, N. Y.
Norfolk Naval Hospital, Portsmouth, Va.
U. S. Naval Hospital, Pensacola, Fla.
U. S. Naval Hospital, San Diego, Calif.
Naval Medical Center, Washington, D. C.
U. S. Naval Hospital, Newport, R. I.
U. S. Naval Hospital, Philadelphia, Pa.
U. S. Naval Hospital, Charleston, S. C.
U. S. Naval Hospital, Great Lakes, Ill.
U. S. Naval Hospital, Mare Island, Calif.
U. S. Naval Hospital, Puget Sound, Bremerton, Wash.

Additional information may be obtained from the Bureau of Medicine and Surgery, Navy Department, Washington, D. C.

FIFTIETH ANNIVERSARY

The Fenwick Sanitarium is celebrating its fiftieth anniversary of continuous operation for the care of nervous and mild mental diseases and drug and liquor addiction.

It was founded by Dr. Frank Fenwick Young at Abbeville, Louisiana, in 1890 and was moved to Covington, Louisiana, in 1912. Dr. F. F. Young is in complete charge of the operation of this Institution and is assisted in this work by several of his sons.

This Institution is registered by the American Medical Association, and is a member of the American Hospital Association, National Association of Private Psychiatric Hospitals, and the Louisiana State Hospital Association.

AMERICAN CONGRESS OF PHYSICAL THERAPY

The Congress will hold its nineteenth annual scientific and clinical session September 2-6, 1940, at the Hotel Statler, Cleveland, Ohio. Complete information may be obtained from the executive office, 30 North Michigan Avenue, Chicago, Ill.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The annual written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 4, 1941, at 2 p. m. Candidates who successfully complete the Part I examinations proceed automatically to the Part II examinations held later in the year.

The American Academy of Ophthalmology and Otolaryngology will hold its forty-fifth annual convention in Cleveland, October 6-11, with headquarters at the Hotel Cleveland.

AMERICAN BOARD OF OPHTHALMOLOGY

There will be only one written examination during 1941. This will be held in various cities throughout the country on March 8.

If you plan on taking your examination during 1941, please write at once to the Board Office, 6830 Waterman Avenue, St. Louis, Missouri. Application must be made on the regular blanks pro-

vided for the purpose and must be received in the Board Office before December 1, 1940.

THE AMERICAN NEUROLOGICAL ASSOCIATION

The American Neurological Association, in its Executive Session at the Westchester Country Club, Rye, New York, on June 7, 1940, unanimously passed the following resolution:

Whereas, official statistics indicate that the immigration of refugee physicians is numerically small, representing in its totality less than .6 per cent of the practicing physicians of this country; and

Whereas, such an influx of physicians from abroad cannot adversely affect the economic welfare of American physicians if the emigrés are distributed widely to those sections of the land in which they are needed; and

Whereas, information gathered from governmental and private investigations indicates that there are at least 2,000 communities in this land in need of immediate medical staffing which in large part cannot be supplied by the graduates of our own medical schools; and

Whereas, many of the demands for physicians come from states in which it has become impossible, either by reason of legal enactments or because of regulations of the state boards, for the refugee physicians to take his medical license examination; and

Whereas, there now exists in New York a competent agency for diverting the unfit among the refugee physicians into non-medical fields, thus making it possible only for those who are fit in training and personality to be considered for examinations;

Now therefore be it RESOLVED, that the State Boards of Medical Examiners in the United States shall create a uniform policy with regard to refugee physicians so as to make possible the wide distribution of these physicians to those places where they are needed throughout the land; and

Further, that these uniform changes in the regulations of our State Boards shall be in the direction of the recommendations, made by Dr. David L. Edsall in his article on "The Emigré Physician in American Medicine" (Journal of the A. M. A., March 23, 1940, Volume 114, pages 1068-1073); and

Finally, that the Committee for Resettlement of Foreign Physicians of the National Refugee Service, Inc., 165 West 46th Street, New York City, shall be utilized as a clearing house for information in regard to available emigré physicians for specific placements.

HASSELTINE TRANSFERRED

The many friends of Medical Director H. E. Hasseltine, U. S. P. H. S., will regret that he has been transferred from the Leprosarium at Carville to a new position in Cincinnati, where he will be Officer in Charge of the Stream Pollution Investigations Laboratory. Dr. Guy E. Faget, who has been in San Francisco, is the new Medical Officer in Charge at Carville.

Senior Surgeon Oswald E. Denney, for many years in charge at Carville, is now Medical Officer in Charge of the U. S. Marine Hospital at Galveston, Texas.

Surgeon Winnfield K. Sharp, Jr., who has been on duty at New Orleans, has been ordered to Washington, D. C.

Dr. George F. Ellinger was commissioned as Assistant Surgeon, U. S. P. H. S., as of June 1, 1940. For several years, Dr. Ellinger was a teacher in the Medical School of Tulane University.

On motion of Dr. James Q. Graves, the nomination by the Board of Regents of Dr. J. H. Musser as a member of the Committee on Medical Education and Hospitals for a term ending in 1947 was confirmed by the House of Delegates of the A. M. A.

INFECTIOUS DISEASES IN LOUISIANA

For the week ending June 22, 1940, the twenty-fifth week of the year, the Bureau of Epidemiology of the Louisiana State Board of Health reported that syphilis headed the reported infectious disease for that week with 164 cases. The next most prevalent disease reported during that week was pneumonia with 57 cases. There followed in order pulmonary tuberculosis with 41, whooping cough and cancer with 32, gonorrhea with 24, typhoid fever with 23, influenza with 19, and malaria with 14. Four of the typhoid fever cases were reported from Orleans Parish, one case of which was listed as imported. There was one case of poliomyelitis from Jeff Davis; three cases of typhus fever were reported. The following week, ending June 29, showed a surprising decrease in the reported cases of syphilis to 53. Pneumonia headed the list for this week with 61 cases, an increase over the previous week. Typhoid fever was reported 14 times, and there were 33 cases of pulmonary tuberculosis, 10 of influenza, 41 of cancer, and 43 of gonorrhea. Five cases of diphtheria were reported and one case of hookworm. For the twenty-seventh week, ending July 6, the major diseases reported were as follows: 99 cases of syphilis, 52 of pneumonia, 26 of pulmonary tuberculosis, 17 of cancer, 15 of malaria, and 12 of typhoid fever. There were three cases of leprosy reported. Two cases of typhus fever were again reported, one from Iberia and one from Orleans. The report for the week ending July 13 showed a total of 22 cases of typhoid fever for this week. While this was a definite increase over the previous week,

it was only about one-half as many cases as had been reported for the same week of last year. The reported cases of whooping cough had increased from four the previous week to 64 this week. There was one case of measles reported; it is remarkable to note that for the same week of 1939 there were 366 cases of measles. The report further showed the following figures: 131 cases of syphilis, 46 of pneumonia, 40 of pulmonary tuberculosis, 32 of cancer, 22 of gonorrhea, and 10 of influenza. There were also reported two cases of epidemic dysentery.

HEALTH OF NEW ORLEANS

For the week ending June 14, 1940, according to the report of the Department of Commerce, Bureau of the Census, there were 123 deaths in New Orleans, of which 77 were white and 46 negro. This was approximately the same as the number of deaths reported for the previous week. The infant mortality for the week totaled 14, eight white and six negro, 10 more than the previous week. There were 119 deaths for the week ending June 22, the proportions being 73 white and 46 negro. The infant mortality under one year of age totaled 11, five white and six negro. There was a definite increase to 140 deaths for the week which closed June 29, of which 83 were white and 57 negro. The infant mortality rate had also increased to 13, six white and seven negro. The following week, ending July 6, the deaths had dropped slightly to 135, 79 white and 56 negro. The infants deaths were also slightly reduced to nine, three white and six negro. To date the total accumulated deaths for the first twenty-seven weeks of this year is 361 as compared to 358 for a like period during 1939.

WOMAN'S AUXILIARY

Louisiana State Medical Society

President—Mrs. Roy Carl Young, Covington.

President-elect—Mrs. Aynaud Hébert, New Orleans.

First Vice-president—Mrs. Joseph E. Heard, Shreveport.

Second Vice-president—Mrs. W. A. Ellender, Houma.

Third Vice-president—Mrs. M. H. Foster, Alexandria.

Fourth Vice-president—Mrs. C. P. Gray, Monroe.

Treasurer—Mrs. M. C. Wiginton, Hammond.

Recording Secretary—Mrs. P. A. Donaldson, Reserve.

Corresponding Secretary—Mrs. Herbert Cannon, Covington.

CHAIRMEN OF STANDING COMMITTEES

Archives, Mrs. D. N. Silverman, New Orleans; Doctors' Day, Mrs. John Clayton, Norco; Exhibits, Mrs. J. S. Dunn, New Orleans; Finance, Mrs. T. H. Watkins, Lake Charles; Historian, Mrs. Edgar Burns, New Orleans; Hygeia, Mrs. Creighton Shute, Opelousas; Indigent Physicians' Fund, Mrs. W. R. Harwell, Shreveport; Legislation, Mrs. C. G. Cole, New Orleans; Organization, Mrs. W. D. Simmons, Covington; Parliamentarian, Mrs. A. A. Herold, Shreveport; Press and Publicity, Mrs. J. W. Rosenthal, New Orleans; Printing and Supplies, Mrs. R. J. Spedale, Plaquemine; Program, Mrs. A. G. McHenry, Monroe; Public Relations, Mrs. J. D. Frazer, DeRidder; Revision of By-laws, Mrs. J. W. Warren, New Orleans.

COUNCILORS

First District, Mrs. G. D. Feldner, New Orleans; Second District, Mrs. R. B. Harrison, New Orleans; Third District, Mrs. R. J. Young, Abbeville; Fourth District, Mrs. E. L. Gill, Shreveport; Fifth District, Mrs. A. D. Tisdale, Monroe; Sixth District, Mrs. A. W. Martin, Bogalusa; Seventh District, Mrs. J. G. McClure, Welsh; Eighth District, Mrs. S. L. Calhoun, Alexandria.

REPORT OF A. M. A. MEETING

Louisiana was represented at the annual meeting of the Woman's Auxiliary to the American Medical Association held in New York City, June 10-14, by two delegates: Mrs. A. A. Herold, of Shreveport, and Mrs. A. D. Tisdale, of Monroe.

The eighteenth session of the Auxiliary was opened in the Grand Ballroom of the Hotel Pennsylvania with Mrs. Rollo K. Packard, of Chicago, presiding. Registration for the first day showed a total of 908 delegates and members including the officers. Thirty-two states were represented, with 37 of the 38 states organized sending exhibits. It was the opinion of those present that more real interest was shown at this meeting than ever before.

Reports of the officers and chairmen of standing committees revealed the vast amount of work done not only by the president and other officers, but by these chairmen as well. Mrs. Packard has proved to be a very efficient president, and her report shows that she has visited 21 states during her term of office. Her recommendations to the Board of Directors, making changes that will prove to be the best policy, show that she has given a great deal of thought to her work.

Organization Chairman, Mrs. Thomas of Pennsylvania, reported a total membership of 23,003 members to date. Of the 6609 counties now organized 66 new ones were reported this year. Exhibit Chairman, Mrs. Beir of New Jersey, very proudly displayed her work with 37 exhibits. These exhibits, for the most part, were posters of scrapbooks showing what the states had done during the

year. Louisiana's exhibits ranked side by side with the others. Public Relations Chairman, Mrs. Mosiman of Washington, presented a most interesting chart showing what each state had done in this work. Since this committee is one of the most important, it was urged by the chairman that we try to create good will and build public opinion by these methods: Acquaint the public with the change that is taking place by the move toward the establishment of political control of medical service; sponsor essays on health; have radio programs on health. Louisiana should be very proud of the report given by Mrs. A. A. Herold, Chairman of Legislation. Her report showed that a program of work to be done had been mailed to all states, with a suggested outline. Every doctor's wife was urged to vote. Her plea was to keep informed. Twenty-nine states reported having a legislative program.

The Program Chairman stated that the most popular programs during the past year were those on socialized medicine, Wagner health bill, medical legislation, cancer, tuberculosis, and maternal welfare. She emphasized that if we are to inform others we must first inform ourselves.

The Wednesday session, again with Mrs. Packard presiding, included the following important features:

1. Memorial services with Mrs. Frank N. Haggard, of San Antonio, Texas, in charge.

2. Resolutions expressing appreciation to the Journal of the A. M. A. for space given the Auxiliary; resolutions pledging support and loyalty to the A. M. A.

3. Reports of the State Presidents: Since only a few minutes were allowed to each one, it was impossible to give complete reports on the fine work done by the individual states.

4. Election of officers, with Mrs. V. E. Holcombe of Charleston, W. Va., taking office as president for the year 1940-41.

Since New York and the World's Fair offered so much in the way of entertainment, it would seem that the Hostess Auxiliary of New York would have nothing to do—but they did. With Mrs. Carlton F. Potter, of Syracuse, as chairman there were more things to do than one could possibly imagine. There was tea at Sherry's on Sunday to begin with, and dinner at the Waldorf-Astoria on Monday for the National Board. The luncheon on Tuesday at Hotel Pennsylvania with 400 guests present, followed by a trip to the Elizabeth Arden Salon for a special presentation of "Beauty in the Making," and the open meeting at the Waldorf-Astoria made indeed a full day. Dr. Morris Fishbein, Editor of the J. A. M. A., and Dr. Rock Sleyster, President of the A. M. A., spoke at the luncheon on Tuesday. At the luncheon on Wednesday Dr. Nathan B. Van Etten, the incoming president of the A. M. A. extended greetings, and Alphonse M. Schwitalla, Ph. D. Dean of St. Louis University, was the guest speaker.

It seemed to be the feeling of all the auxiliary members that the doctors themselves realize as never before what a potential power the auxiliary is and can be and that they want us to work as never before.

Signed: Leta S. Tisdale
(Mrs. A. D. Tisdale)
Delegate from Louisiana.

Respectfully submitted,
Mrs. Jonas W. Rosenthal,
Press and Publicity Chairman.

BOOK REVIEWS

International Clinics, March, 1939: Edited by George Morris Piersol, M. D. Philadelphia, J. B. Lippincott Co., 1939. Pp 312. Price $2.50.

This volume should prove of interest, especially to clinicians. Among the essays noteworthy for information as well as for interest, may be mentioned a "Review of Gastroscopy"; "Significance of Hemorrhage in the Gastrointestinal Tract," and an "Outline of Electrocardiography" by Dr. Richard Ashman.

I. L. ROBBINS, M. D.

Directory of Medical Specialists, Certified by American Boards 1939: Edited by Paul Titus and J. Stewart Rodman. New York City, Columbia University Press, 1940. Pp. 1573. Price $5.00.

This, the only official Directory of its kind, lists approximately 14,400 Diplomates certified by the twelve special American Boards and one of the two affiliate boards.

A separate section is devoted to each American Board, with both a geographic and a biographic listing of its Diplomates. In addition, there is a complete alphabetic list of all the 14,400 Diplomates. In this list there are addresses and indications of specialty certification, while in the geographic sections complete biographic information is given. The organization and examination requirements of each of the American Boards are explained in full.

COLUMBIA UNIVERSITY PRESS.

Manual of Dermatology: By Carroll S. Wright, B. S., M. D. Philadelphia, The Blakiston Co., 1940. Pp. 376. Price $4.00.

This handy compendium, stressing the more common dermatoses which make up the bulk of the skin diseases seen in general practice, admirably suits its purpose. The manual is not intended to be an encyclopedic treatise on dermatology but instead to serve as a small text or reference work for medical students or for the busy practitioner of medicine.

A brief descriptive style has been adhered to and under each dermatologic condition concise paragraphs are given on synonyms, definitions, symptoms, pathology, diagnosis, prognosis, and treatment. The majority of the therapeutic measures recommended are those found useful and practicable by the author and are limited to the few modes which are most likely to be successful in the given case. The inclusion of up-to-date prescriptions is most commendable.

It is interesting to note the frequent reference to the value of superficial and filtered x-ray therapy in dermatologic treatment, emphasizing the statement made thirty years ago by William Allen Pusey: "It is hardly too much to say that roentgenotherapy is the most widely useful addition to the treatment of skin diseases that has been made."

M. D. LANG, M. D.

Clinical Parasitology: By Charles Franklin Craig, M. D., M. A. (Hon.), F. A. C. S., F. A. C. P., Col., U. S. Army (Retired), D. S. M., and Ernest Carroll Faust, M. A., Ph. D. Philadelphia, Lea and Febiger, 1940. Pp. 772. Price $8.50.

This volume of 772 pages by two well-known authorities is made up of nine chapters on protozoa and protozoan infections, nineteen chapters on helminths and helminthic infections, and eleven chapters on arthropods and human disease. A technical appendix of 50 pages, references to the extent of 26 pages, and subject and author indices, are provided.

The volume is adequately illustrated, many of the drawings being original. The clinical sections are generally brief, but sufficient and to the point; thus, under plague we find the following: "There is no satisfactory treatment for the disease," which is better than enumerating a host of agents of little or no worth.

Under the prevention of amebic dysentery the authors advocate the examination and treatment of food handlers employed in public eating places. We can readily agree that, theoretically, this measure in addition to others mentioned by the authors would be desirable, but application as a practical public health measure has not seemed possible to many sanitary authorities. The reviewer does not know of any important community in which the measure has been continued though it was inaugurated in many places after the tragic experience of Chicago in 1933.

Referring to swine as sources of human trichinosis, the authors do not differentiate between the types of feeding, e.g., grain-fed as against garbage-fed animals, nor do they mention "splinter hemorrhages" in the clinical diagnosis in man. Perhaps both these omissions are to be accounted for by the recentness of this publication.

The book presents the several subjects in authoritative and clear form. Suitable as a textbook for special students, it is perhaps more comprehensive than the medical student would need, though he could use it with great profit. Teaching of parasitology is notably deficient in many of our medical schools, and it is to be hoped that this volume will aid teachers who are not specialists in presenting the subject.

G. W. MCCOY, M. D.

Treatment of War Wounds and Fractures, with Special Reference to the Closed Method as Used in the War in Spain: By J. Trueta, M. D. New York, Paul B. Hoeber, Inc., 1940. Pp. 146. Price $2.50.

This is a small book from the standpoint of size only. Containing a foreword by H. Winnett Orr, it is a vindication of the Orr method of treating wounds. A brief description of various methods of wound management since Paré indicate the vacillating trends in an attempt to find some chemical treatment for wounds. None has been found and rest and protection from repeated reinfection has proved itself as demonstrated again by Dr. Trueta under war conditions an outstanding method. The very nice photographs of war wounds before and after such treatment illustrate more vividly than the text the good results.

Fortunately this method has already received considerable publicity from its use in the Spanish Civil War. Most lay publicity has been of this sort so that an impression has spread that the method was developed and used first during that war. Such is far from the truth. It is American and it has gone abroad and returned to us under a different name. H. Winnett Orr deserves great credit for initiating this treatment of wounds and compound fractures; Dr. Trueta deserves credit for this demonstration of its value in military surgery.

HOWARD MAHORNER, M. D.

Injuries of the Skull, Brain and Spinal Cord: Edited by Samuel Brock, M. D. Baltimore, Williams and Wilkins Co., 1940. Pp. 632. Price $7.00.

This extraordinarily effective and serviceable treatise covers a wide range of subjects and is a balanced, authoritative, precise discussion of the known facts concerning injuries of the skull, brain and spinal cord in their neurologic, psychiatric,

surgical, medico-legal, and other relations. New developments in diagnosis, differential diagnosis and treatment are detailed in clear, concise language.

It is by no means easy to give a satisfactory summary estimate in this brief review but there are twenty-two parts which are mutually related in the production of an unusually complete, single volume. Each chapter is the work of a distinguished specialist and leading authority in his field and, aside from the point of view of one's special interests, it is quite difficult to attempt to determine which contributor has presented the best section. Dr. Symonds' presentation is very good and his views on convalescence in concussion and contusion of the brain are worthy of much notice. Particularly outstanding and well written chopters are those on "Neuroses Following Head and Brain Injuries"; "Psychotic States Following Head and Brain Injuries in Adults and Children"; "Simulation (Malingering) in Relation to Injuries of the Skull, Brain and Spinal Cord." The material appearing in them is of great value.

One rarely comes upon anything so perfectly done as is this book edited by Samuel Brock. It is accurate, authoritative, comprehensive, and lucid. It should be indispensable to doctors, lawyers, and those who deal with injuries and claims for insurance benefits and compensation.

The editor, the contributors and the publishers are to be heartily congratulated for creating this excellent manual which is, in every way, worthy of the subjects covered and which supplies a long felt want and is of vital interest to medical science.

C. P. MAY, M. D.

Dermatologic Allergy: By M. B. Sulzberger, M. D. Springfield, Ill., Charles C. Thomas Co., 1940. Pp. 540. Price $8.50.

The author of this book needs no introduction to medical men. Dr. Sulzberger has devoted his career to the subject of this work, and the present volume is the most comprehensive work thus far available in this field.

The text is well written; the descriptions are detailed and painstaking. The author is to be highly commended for keeping this a book of clinical information. The reviewer was particularly impressed with the comprehensive clinical discussions of atopic dermatitis and of urticaria. The bibliography is pertinent rather than comprehensive. A glossary is an unusual feature of the book. The illustrations are good and well chosen. Numerous tables and marginal notes facilitate the reading of the text.

Dr. Sulzberger astutely defends the rationale of skin tests, despite the fact that the hitherto available empiric evidence would vitiate such a position. The whole subject of the evaluation of skin tests requires a new orientation because of the introduction of purified and concentrated extracts into the field. The new empiric evidence substantiates the author's hypothesis concerning the clinical evaluation of skin sensitivity to allergens.

Only one note of adverse criticism must be mentioned. In common with most writers on medical subjects, the author fails to use efficient statistics for the analysis of his data. This is regrettable since the utilization of statistical knowledge would have materially enhanced the value of his conclusions.

The book is well worth while, for it does much to clear up the mental confusion that exists regarding this subject. The work should be a necessary item in the library of every dermatologist, internist, and allergist.

B. G. EFRON, M. D.

PUBLICATIONS RECEIVED

M. Barrows & Company, Inc., New York City: Simplified Diabetic Manual, by Abraham Rudy, M. D.

The Commonwealth Fund, New York City: Psychiatric Clinics for Children, by Helen Leland Witmer, Ph. D.

F. A. Davis Company, Philadelphia: Medical Nursing, by Edgar Hull, M. D., F. A. C. P., Christine Wright, R. N., B. S., and Ann B. Eyl, B. S.

The Haynes & George Company, Inc., Newark, N. J.: The Era Key to the USP XI & NF VI, revised by Lyman D. Fonda.

Hospital Textbook Company, New York City: Legal Guide for American Hospitals by Emanuel Hayt, LL. B., and Lillian R. Hayt, M. A., J. D.

Lea & Febiger, Philadelphia: The Diagnosis and Treatment of Pulmonary Tuberculosis, by John B. Hawes, 2d, M. D., and Moses J. Stone, M. D. A Manual of Otology, Rhinology and Laryngology, by Howard Charles Ballenger, M. D., F. A. C. S.

J. B. Lippincott Company, Philadelphia: Modern Dermatology and Syphilology, by S. William Becker, M. D., and Maximillian E. Obermayer, M. D.

W. B. Saunders Company, Philadelphia: Clinical Diabetes Mellitus and Hyperinsulinism, by Russell M. Wilder, M. D., Ph. D., F. A. C. P.

University of Chicago Press, Chicago: Graduate Medical Education, Report of the Commission on Graduate Medical Education, Willard C. Rappleye, A. B., A. M., Sc. D., Chairman.

The Williams & Wilkins Company, Baltimore: The Surgery of the Alimentary Tract, by Sir Hugh Devine, M. S., F. R. A. C. S., F. A. C. S. A Method of Anatomy, by J. C. Boileau Grant, M. C., M. B., Ch. B., F. R. C. S. (Edin.). A Handbook for Dissectors, by J. C. Boileau Grant and H. A. Cates.